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State Medicaid Outpatient Prescription Drug Policies: Findings from a National Survey, 2005 Update

Prepared by

Jeffrey S. Crowley and Deb Ashner
Health Policy Institute, Georgetown University

and

Linda Elam, Kaiser Commission on Medicaid and the Uninsured

October 2005

THE HENRY J. KAISER FAMILY FOUNDATION

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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

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ACKNOWLEDGMENTS

The authors would like to thank the state Medicaid officials who were instrumental to completing this survey. We are especially appreciative of the commitment they have shown in helping us ensure that the results presented are as accurate as possible by responding to a relatively comprehensive survey and reviewing draft data tables.

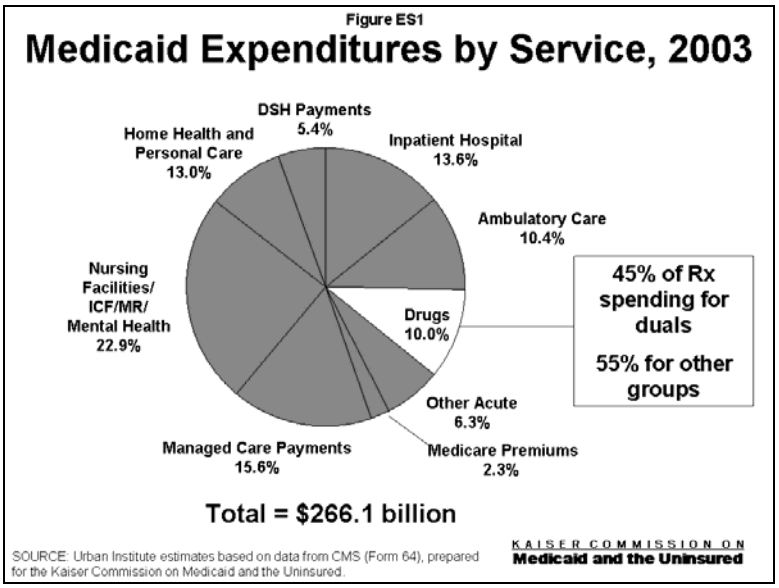
TABLE OF CONTENTS

EXECUTIVE SUMMARY

The populations served by Medicaid and the diversity and intensity of their health care needs make Medicaid a major purchaser of prescription drugs. In 2003, Medicaid spent $33.7 billion on prescription drugs, accounting for 19% of national spending for this service.[i] Comprehensive prescription drug coverage is an essential benefit for Medicaid's 58.5 million low-income beneficiaries, including 9.2 million non-elderly people with disabilities and 5.4 million seniors, cohorts that are especially reliant on pharmaceuticals for the management of chronic illness.[ii]

In 2005, a broad spectrum of policy makers is focused on ways to reduce Medicaid spending growth. At the federal level, the Congressional budget resolution for fiscal year 2006 (which began on October 1, 2005) calls for the Senate Finance Committee to achieve savings of $10 billion over the next five years by identifying savings in the programs under its jurisdiction (and a corresponding level of savings is required from the House Energy and Commerce Committee). Even amid the changing priorities prompted by Hurricane Katrina, it is believed that a significant portion of these savings will come from Medicaid—and several policy makers have identified prescription drug policy changes as one of the primary ways that the Congress could meet the budget resolution's budget reduction target.

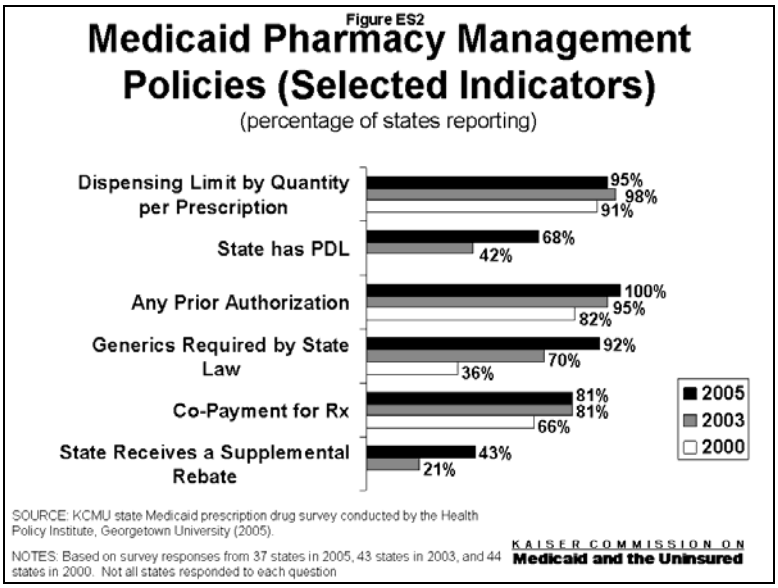
Medicaid will undergo additional changes as a result of the implementation of the Medicare Modernization Act (MMA)[iii]. On January 1, 2006, an estimated 13.6% of current Medicaid beneficiaries, who account for 48% of Medicaid prescription drug spending, will be transitioned to Medicare prescription drug coverage.[iv] Medicaid programs will have continued responsibility for meeting the long-term services and supports needs of dual eligibles and will continue to fill in for other gaps in Medicare coverage, even though they are barred by the MMA from receiving federal Medicaid financing for filling in any gaps in Medicare drug coverage **(Figure ES1)**. They will also be responsible for continuing Medicaid drug coverage for those beneficiaries who are not dual eligibles, but the amount spent and the mix of drugs purchased through the program will change considerably.



In the first half of 2005, the Kaiser Commission on Medicaid and the Uninsured conducted a survey of state Medicaid prescription drug policies that was carried out by the Health Policy Institute at Georgetown University. Thirty-six states plus the District of Columbia responded to the survey.[v] This survey updates and supplements work conducted for the Commission in 2003 and 2000 and covers key elements of utilization management, drug purchasing and potential impacts of the implementation of Medicare Part D.[vi]

Summary and Highlights from the 2005 Survey

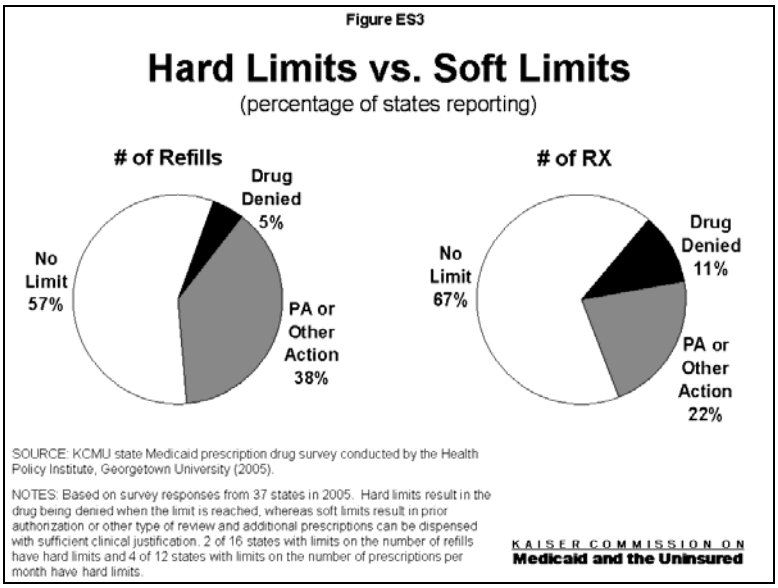
States have several tools available to them to manage the pharmacy benefit and to control costs. Increased health care costs and recent fiscal constraints have led most state Medicaid programs to use many of these tools. Medicaid programs anticipated 14.3% growth in drug spending in fiscal 2005, continuing a trend of double-digit growth. Consequently, in 2005, among responding states, nearly all programs used dispensing limits; roughly two-thirds operated preferred drug lists (PDLs); all required some prior authorization; nearly all required the use of generics, and four in five states charged co-payments for prescription drugs **(Figure ES2)**.



Dispensing Limits: In 2005, nearly all programs (35 of 37) reported that they impose limits on the amount of a drug that can be dispensed per prescription; lesser numbers imposed limits on refills per prescription (16 of 37) or number of prescriptions (12 of 37).

- **New Finding in 2005: Most states with dispensing limits apply soft limits**

Policy makers and beneficiary groups have focused on the imposition of hard dispensing limits in a small number of states, where beneficiaries may be denied medically necessary drugs above the established limit. While the ability of states to establish limits on dispensing is not new, the use of hard limits versus soft limits may reflect a new policy direction. In states with hard limits, Medicaid will not pay for drugs dispensed to an individual above a certain number of prescriptions or refills. Under soft limits, when individuals reach the established limit, their subsequent prescriptions typically become subject to prior authorization. Providers are given the opportunity to provide clinical justification for prescribing drugs above the limit, but drugs may be denied at this stage. States were asked in 2005 what action they take when beneficiaries hit the limits on the number of refills and the number of prescriptions. In most cases, individuals are subject to some form of prior authorization. In only 13% of responding states (2 of 16 states in 2005) are individuals automatically denied drugs (i.e., a hard limit is imposed) with respect to the number of refills and in only 33% of responding states (4 of 12 states in 2005) are individuals automatically denied drugs with respect to the number of prescriptions **(Figure ES3)**.



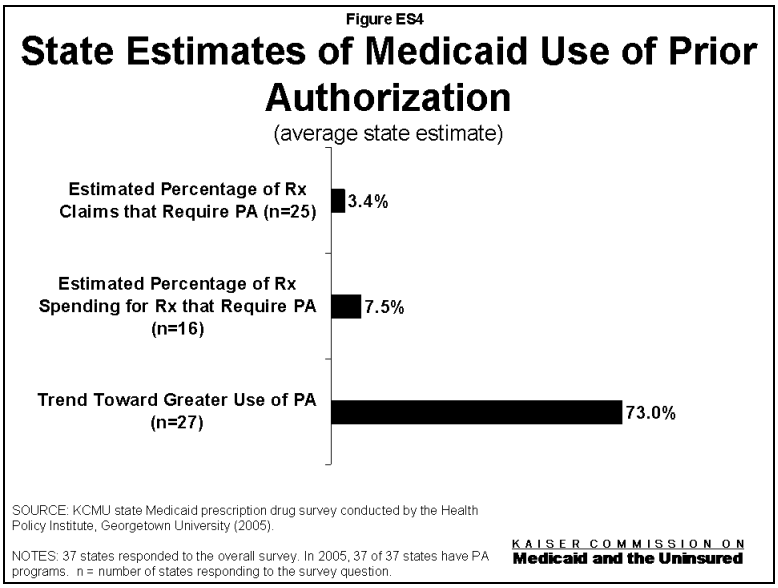
Preferred Drug Lists (PDLS)*:* In 2005, more than two-thirds of responding states operated PDLs. Of those with PDLs, most states provide for public input into drugs that should be on the PDL, and 40% use the same PDL for other state programs such as the State Children's Insurance Program (SCHIP) or the State Pharmacy Assistance Program (SPAP).

Prior Authorization (PA): In 2005, all responding states required PA for certain drugs paid for by Medicaid, and roughly three-fourths reported that the recent trend has been toward a greater reliance on PA. Three-fourths also indicated that they exempt certain classes of drugs from PA.

- **New finding in 2005: While all surveyed states use prior authorization (PA), states apply it selectively**

While PA has become a central pharmacy cost containment strategy in virtually all states, PA is used selectively. On average, states estimate that only 3.4% of prescription drug claims are for drugs that require PA (based on estimates from 25 states in 2005) **(Figure ES4)**. Additionally, the average estimate is that only 7.5% of Medicaid prescription drug spending is for drugs that require PA (based on estimates from 16 states). Some policy makers may interpret these low percentages to indicate that states could require PA for far more drugs. The success of PA programs, however, may rely on targeting efforts appropriately. Nonetheless, roughly three-fourths of respondents (27 of 37 states in 2005) reported that the recent trend has been toward a greater reliance on PA.

Figure ES4



***Generic Substitution**:* In 2005, nearly all states (34 of 37 responding) reported that they require generics to be dispensed when available, but the majority of these states (30 of 34) permit the requirement to be overridden if the prescriber requests. States estimated that 52% of prescriptions are filled with generics and that 19% of Medicaid drug spending is for generics.

***Cost Sharing**:* In 2005, four in five states (30 of 37 responding) charged co-payments for Medicaid prescription drugs. Seven of those 30 report that they permit prescription drugs to be withheld for non-payment of cost sharing.

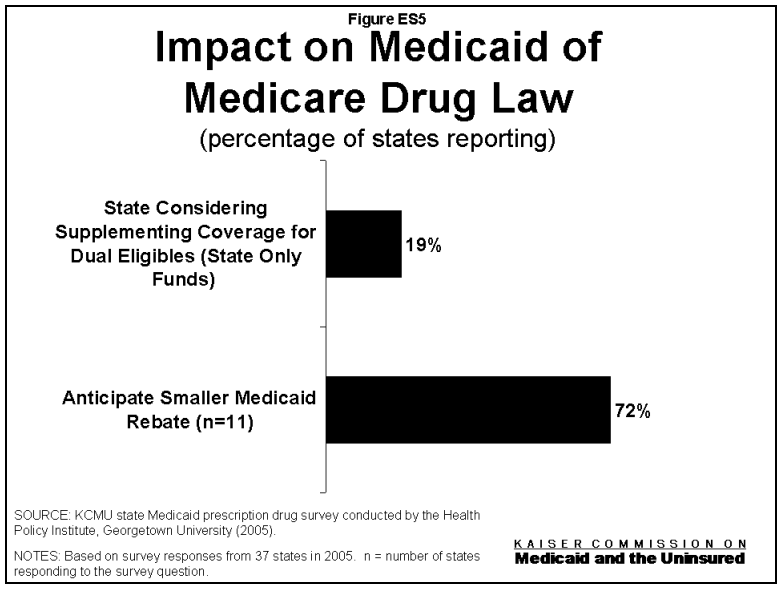
High Cost Management: In 2005, 23 of 37 responding states reported that they operate special programs targeting high cost patients who are identified sometimes using claims data or by chronic condition (e.g., diabetes or asthma). States typically use strategies such as disease management and provider education to address these groups.

Drug Purchasing: While the proportion of states receiving supplemental rebates has increased over time, fewer than half (16 of 37 responding in 2005) reported receiving them. A little more than half of responding states (20 of 37) reported returning rebate payment to Medicaid, with the remainder applying rebate payments to the state general fund. Six of 37 states reported pooling drug purchasing across several states, and three of 37 reported pooling drug purchasing across several state programs.

Impact on Medicaid of Medicare Drug Coverage: Early in Medicare drug coverage implementation, a minority of states reported considering using Medicaid to fill gaps in coverage for dual eligibles, yet the majority of surveyed states anticipated that the MMA will lead to smaller Medicaid rebates.

The implementation of the Medicare Modernization Act (MMA) has the potential to improve access to prescription drugs for millions of Medicare beneficiaries. The impact on dual eligibles, however, is unclear. CMS in its rulemaking and subsequent guidance has taken steps to ensure that Medicare Part D plan formularies are comprehensive, including the requirement that plans cover substantially all drugs in six key classes: anticonvulsants; antidepressants; antineoplastics; antipsychotics; antiretrovirals, and immunosuppressants.

Nonetheless, states and many other stakeholders are concerned that coverage gaps will arise for dual eligibles, both because plans will not cover necessary medications or because drugs will be denied due to the inability to pay cost-sharing. Some states (7 of 37 states in 2005) reported that they are actively considering using state-only funds to fill in gaps in Medicare coverage **(Figure ES5)**. While many state respondents said that they could not anticipate the impact of the implementation of the MMA on Medicaid, of those responding, nearly three-fourths indicated a belief that their Medicaid program would receive smaller rebates due to the loss of market share (8 of 11 states responding to this question in 2005).



Conclusion

Until now, Medicaid has played a unique role in providing access to prescription drugs to the neediest and costliest cohorts of Americans (low-income people with severe disabilities and low-income elderly individuals). Beginning in 2006, this responsibility will be shared with the Medicare Part D prescription drug program. Medicaid programs will grapple with the impact of the MMA on prescription drug costs and access for the remainder of the Medicaid population. Meanwhile, the Congress is considering changes to some of the basic approaches to purchasing prescription drugs in Medicaid and sharing responsibility for costs with beneficiaries. What will not change is the

central role that prescription drugs have come to play in modern health care and their vital role in the health and functioning of many of the poorest and sickest Americans.

The results presented are based on self-reported data by state Medicaid pharmacy officials. Participating states responded to a written survey or provided information through telephone interviews in the first half of 2005. Participating states were given the opportunity to review their responses for accuracy in July-August 2005, and states were asked to ensure that policies were up-to-date in cases where policies may have changed since originally completing the survey. Multiple efforts were made to secure the participation of all states.

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[i] *National Health Expenditures Tables, 2003,* Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, January 2005.

[ii] Congressional Budget Office, March 2005 Baseline.

[iii] The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), also called Medicare Part D (Public Law 108-173), creates a right for Medicare beneficiaries to purchase Medicare prescription drug coverage beginning on January 1, 2006. While technically voluntary, low-income Medicare beneficiaries who also receive Medicaid (dual eligibles) will lose their Medicaid drug coverage and will be automatically enrolled in a Medicare prescription drug plan.

[iv] John Holahan and Arunabh Ghosh, *Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2003*, Kaiser Commission on Medicaid and the Uninsured, July 2005.

[v] For ease of reference, throughout this report, references to "states" should be inferred to include the District of Columbia.

[vi] For 2003 survey, go to http://www.kff.org/medicaid/4164.cfm. For 2000 survey, go to http://www.kff.org/medicaid/2225-index.cfm.

INTRODUCTION

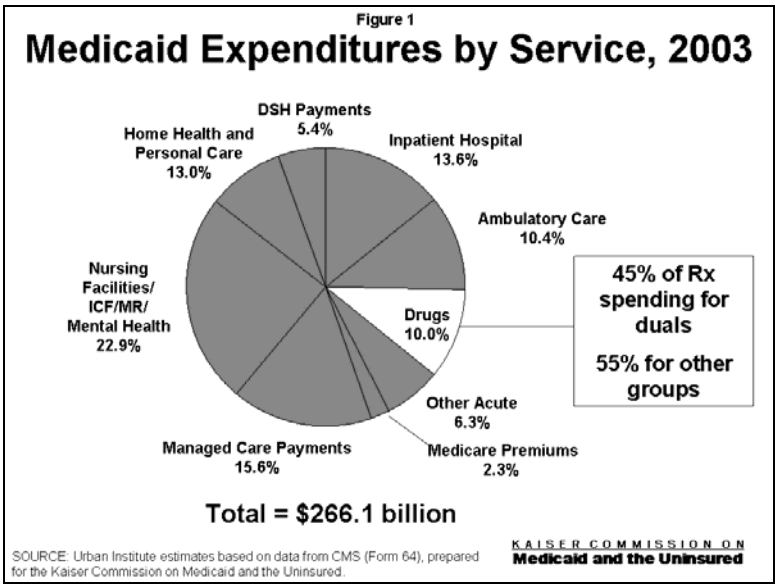
Increasing health care costs and numbers of uninsured or under-insured individuals are placing the nation's health care payers under great stress, whether public programs such as Medicaid and Medicare or the private insurance system. As a consequence, policy makers are continually looking for new and better strategies for improving care and controlling costs. Prescription drug spending has been a major target in recent years because of its double-digit growth rates over several years. In 2003, national spending on prescription drugs totaled $179.2 billion, accounting for 11% of national spending on health care and related services,[1] and spending growth on prescription drugs was 10.7% greater than in 2002.[2] This increase is driven by an increasing number of prescriptions per person; changes in the types of drugs used—with an increased reliance on newer and more expensive drugs, and manufacturer price increases.[3]

Although low-income children and parents make up three quarters of the Medicaid population, they account for only 31% of Medicaid spending. The other 69% of program spending is attributable to the elderly and people with disabilities, who make up only one-quarter of the Medicaid population. These populations and the diversity and intensity of their health care needs make Medicaid a major purchaser of prescription drugs. Medicaid programs accounted for 19% of national spending on prescription drugs in 2003 ($33.7 billion).[4] Comprehensive prescription drug coverage is an essential benefit for Medicaid's 58.5 million low-income beneficiaries, including 9.2 million non-elderly people with disabilities and 5.4 million seniors, cohorts that are especially reliant on pharmaceuticals for the management of chronic illness.[5]

In 2005, a broad spectrum of policy makers is focused on ways to reduce Medicaid spending growth. At the federal level, the Congressional budget resolution for fiscal year 2006 (beginning on October 1, 2005) calls for the Senate Finance Committee to achieve savings of $10 billion over the next five years by identifying savings in the programs under its jurisdiction (and a corresponding level of savings is required from the House Energy and Commerce Committee). Even amid the changing priorities prompted by Hurricane Katrina, it is believed that a significant portion of these savings will come from Medicaid—and several policy makers have identified prescription drug policy changes as one of the primary ways that the Congress could meet the budget resolution's budget reduction target. However, the climate for Medicaid cuts may have chilled given changing priorities in the wake of Hurricane Katrina.

Other changes to the Medicaid program will follow the implementation of the Medicare Modernization Act (MMA) which has significant implications for Medicaid programs and beneficiaries.[6] Medicaid currently provides drug coverage for low-income Medicare beneficiaries (dual eligibles) which will end on December 31, 2005, with Medicare prescription drug coverage beginning on January 1, 2006. Dual eligibles constitute an estimated 13.6% of current Medicaid beneficiaries, responsible for roughly 45% of Medicaid prescription drug spending.[7] Medicaid programs will have continued responsibility for meeting the long-term services and supports needs of dual eligibles

and will continue to fill in for other gaps in Medicare coverage, even though they are barred by the MMA from receiving federal Medicaid financing for filling in any gaps in Medicare drug coverage **(Figure 1)**. They will also be responsible for continuing Medicaid drug coverage for those beneficiaries who are not dual eligibles.



In the first half of 2005, the Kaiser Commission on Medicaid and the Uninsured conducted a survey of state Medicaid prescription drug policies that was carried out by the Health Policy Institute at Georgetown University. Thirty-six states plus the District of Columbia responded to the survey.[8] This survey updates and supplements work conducted for the Commission in 2003 and 2000.[9] The supplement examined enrollment and state Medicaid policies in the following areas:

1. Outpatient Drug Spending
2. Dispensing Limits
3. Preferred Drug Lists (PDLs)
4. Prior Authorization
5. Generic Substitution
6. Cost-Sharing
7. High Cost Management
8. Purchasing Policies
9. Impact on Medicaid of Medicare Drug Coverage

The results presented are based on self-reported data by state Medicaid pharmacy officials. Participating states responded to a written survey or provided information through telephone interviews in the first half of 2005. Participating states were given the opportunity to review their responses for accuracy in July-August 2005, and states were asked to ensure that policies were up-to-date in cases where policies may have changed since originally completing the survey. Multiple efforts were made to secure the participation of all states.

The appendix includes tables of survey responses from individual states (tables 1-19). Throughout the survey, respondents were asked to provide quantitative responses. In some cases, these data were readily available; in others, respondents provided their best estimates based on their professional experience. While some of these data are estimates rather than precise figures, they nonetheless offer important insights on some of the most pressing prescription drug policy issues facing Medicaid programs.

As a starting point toward understanding differences in the use of Medicaid pharmacy services, states were asked to provide their Medicaid enrollment and the average number of monthly prescriptions dispensed to all Medicaid beneficiaries, by dual eligibles, and by Medicaid beneficiaries residing in nursing homes and other institutions. **Table 1** provides summary data on Medicaid enrollment. While states do not uniformly track prescription drug use by the requested measures, a subset of survey respondents was able to provide estimates for their state **(Table 2).**

DRUG SPENDING

Table 3

Medicaid officials expected prescription drug costs to continue to increase at double digit rates. On average, states estimated that drug spending will increase 14.3% in the current state fiscal year (based on estimates provided by 33 states in 2005) **(Figure 2)**. States also estimated that Medicaid spending grew 12.9% in the last fiscal year (based on estimates by 35 states in 2005). These estimates are consistent with previous state estimates. In 2003, state estimates of recent past spending and spending over the current year ranged from 13.8% to 14.7%.

Figure 2

Average Estimated Annual Increases in Medicaid Prescription Drug Spending

SOURCE: KCMU state Medicaid prescription drug survey conducted by the Health Policy Institute, Georgetown University (2005).

NOTES: Based on survey responses from 37 states in 2005. 33 states provided a projected growth estimate and 35 states provided an estimate for last year's growth.

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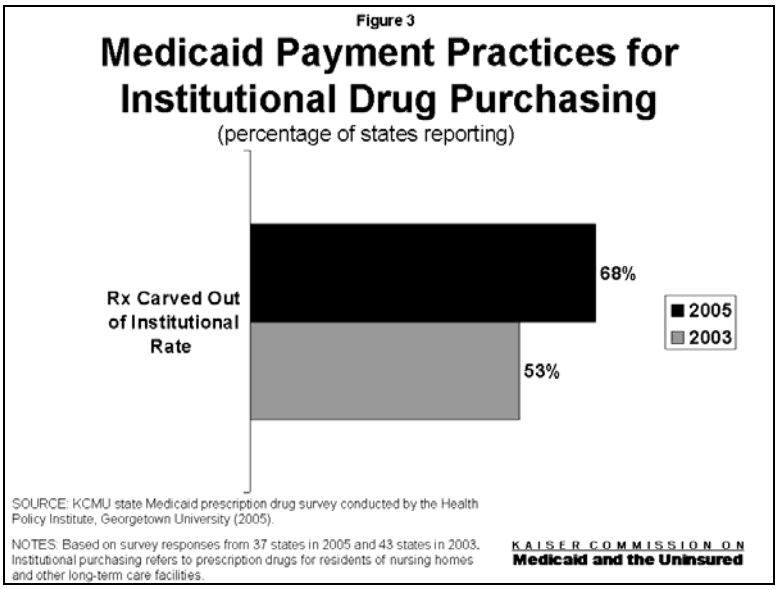
Payments for most Medicaid services for beneficiaries residing in the community are based on individual claims for services they use, and payments for prescription drugs are based on individual claims for products that were dispensed or paid as part of a

capitation rate to a health plan. States take different approaches to purchasing prescription drugs in nursing homes and other long-term care facilities and these costs are often bundled and paid on a daily rate. While bundling prescription drugs into the daily rate may simplify administration, it also means that states cannot take advantage of Medicaid rebates for drugs reimbursed in this manner. Moreover, it means that states are dependent on institutional providers—or the long-term care pharmacies with which they contract—to take responsibility for ensuring the most efficient purchasing of prescription drugs. More than two-thirds of states (68%, 25 of 37 states in 2005) reported that they carve out (or pay separately for) prescription drugs provided to residents of long-term care facilities **(Figure 3)**.



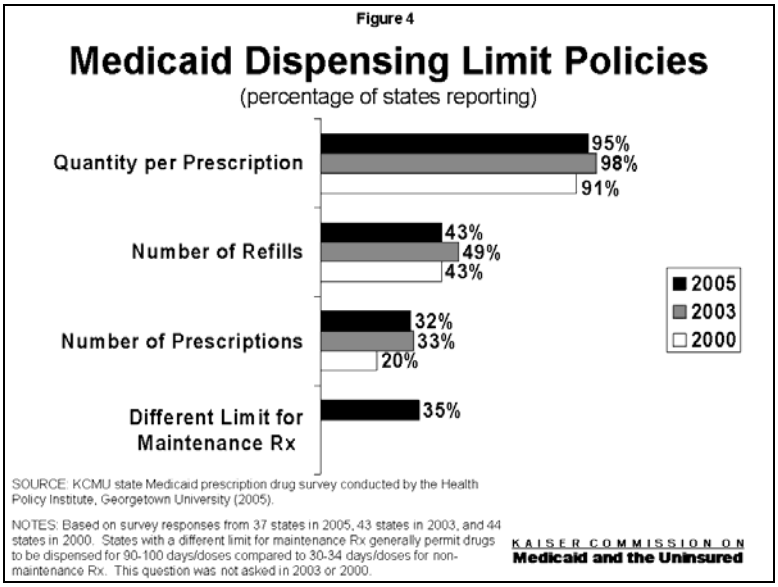
DISPENSING LIMITS
Tables 4-6

Federal Medicaid law requires states to ensure that benefits they provide are "sufficient in amount, duration, and scope to reasonably achieve (their) purpose".[10] However, under federal regulations, states may place "appropriate" limits on a service based on "medical necessity or on utilization control procedures".[11] The Medicaid law also permits states, "to impose limitations, with respect to all such drugs in a therapeutic class, on the minimum or maximum quantities per prescription or on the number of refills if such limitations are necessary to discourage waste". [12]

Dispensing Limits: State policies that restrict the quantity of prescription drugs that Medicaid will purchase for a Medicaid beneficiary.

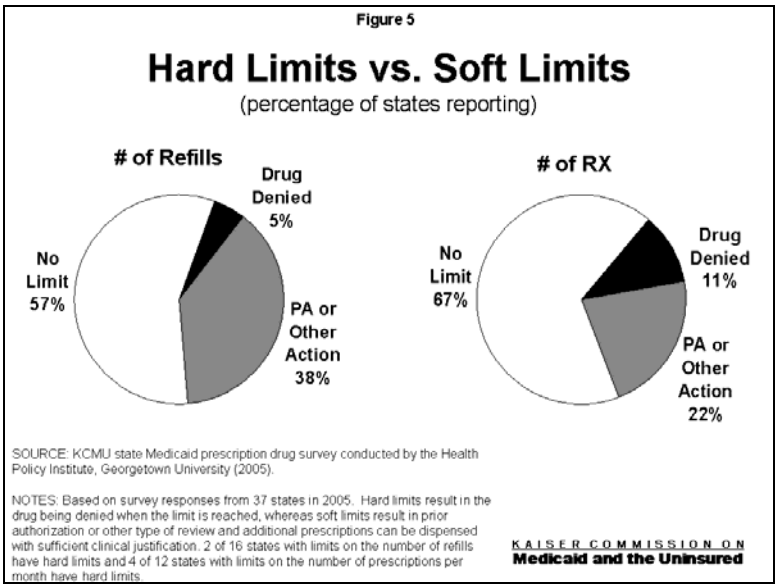
Nearly all Medicaid programs placed limits on the quantity of medication that can be dispensed per prescription (35 of 37 states in 2005) **(Figure 4)**. Several states (16 of 37 states in 2005) also placed limits on the number of refills per prescription and on the number of prescriptions (12 of 37 states in 2005). In response to a question that had not been asked in

the previous surveys, roughly one-third of states (13 of 37 states in 2005) report that they maintain different dispensing limits for maintenance drugs (i.e., drugs taken for long-term management of chronic conditions).



Recent attention has been focused on the imposition of hard limits in a small number of states, in which beneficiaries may be denied medically necessary drugs above the established limit (i.e., Medicaid pays for only those prescriptions up to the limit). While the ability of states to establish such policies is not new, the use of hard limits versus soft limits may reflect a new policy direction. In states with hard limits, an individual cannot obtain drugs above the limit. In states with soft limits, when individuals reach the established limit, they become subject to prior authorization or some other form of review. Drugs may be denied at this stage, but individuals are given the opportunity to provide clinical justification for receiving drugs above the limit.

States were asked what actions they take when beneficiaries reach limits on the number of refills and the number of prescriptions. (Quantity limits do not generally present an access issue as the limit affects the amount of drug an individual can get at one time, but not whether they can obtain all of the drugs they have been prescribed). In most cases, drugs prescribed over the limit are subject to some form of prior authorization. In only 13% of responding states (2 of 16 states in 2005) are individuals automatically denied drugs (i.e., a hard limit is imposed) with respect to the number of refills and in only 33% of responding states (4 of 12 states in 2005) are individuals automatically denied drugs with respect to the number of prescriptions **(Figure 5)**.



PREFERRED DRUG LISTS (PDLs)
Tables 7-8

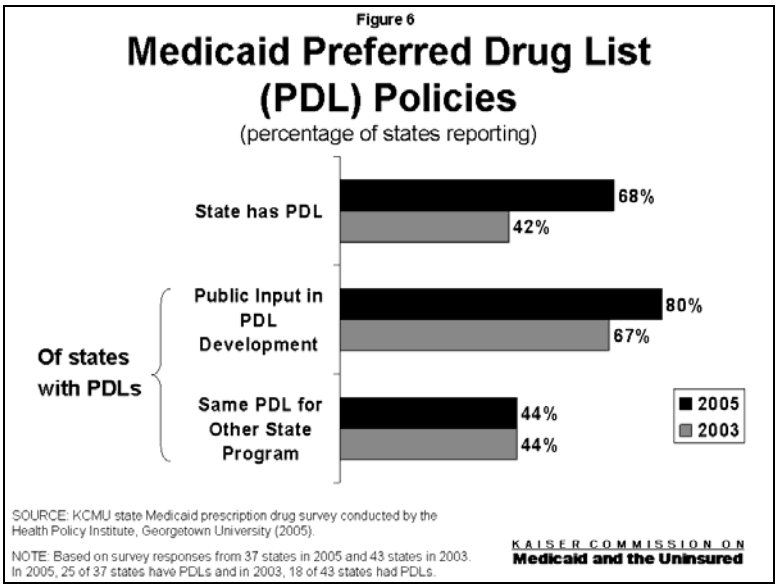
Preferred drug lists (PDLs) are equivalent to formularies. The Medicaid law permits states to establish formularies subject to certain requirements.[13] The formulary must be established by a Pharmacy and Therapeutics (P&T) committee that is appointed by the Governor (or the state drug use review board) and that must include physicians, pharmacists, and other appropriate individuals. The formulary must include all drugs made by manufacturers with rebate agreements in effect with HHS (except for drugs excludable under Medicaid law)[14] unless the drug excluded from the formulary, "does not have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness, or clinical outcome of such treatment for such population over other drugs included in the formulary and there is a written explanation (available to the public) of the basis for the exclusion".[15] The Secretary is also permitted to impose additional requirements to "achieve program savings consistent with protecting the health of program beneficiaries".[16]

Preferred Drug List (PDL):
A list of covered prescription drugs that a state Medicaid program agrees to provide without prior authorization.

All other medically necessary pharmaceuticals require prior authorization.

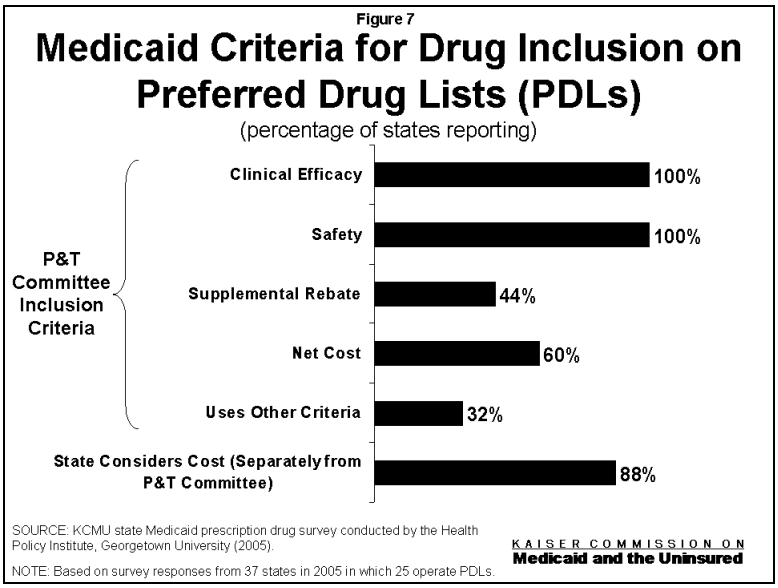
The development and implementation of PDLs in some state Medicaid programs has met with controversy. Some beneficiary groups have opposed the establishment of PDLs citing potential drug access problems. States may consider several criteria for PDL inclusion, but many states have made a point of highlighting the significance of clinical evidence in constructing their PDLs. In some, but not all states with PDLs, the use of clinical evidence and transparency in the process for establishing the PDL have eased some concerns raised by beneficiaries and other stakeholders.

More than two-thirds of states operate PDLs (25 of 37 states in 2005), a significant increase over the 42% of states with PDLs in 2003 (18 of 43 states in 2003) **(Figure 6)**. Of states with PDLs, most provide for public input into the process of determining which drugs will be included on the PDL (20 of 25 states in 2005). Forty percent (10 of 25 states in 2005) use the same PDL for other state programs, such as the State Children's Health Insurance Program (SCHIP) or the State Pharmacy Assistance Program (SPAP).



States were asked what criteria the P&T committee uses to decide which classes of drugs to place on the PDL and which specific drugs are included. Of those states with PDLs, all states (25 of 25 states in 2005) reported that the P&T Committee considers clinical efficacy and safety **(Figure 7)**. Forty-four percent of states reported that the P&T Committee considers whether the state receives a supplemental rebate (11 of 25 states in 2005) and 60% indicate that the P&T Committee considers the net cost of drugs (15 of 25 states in 2005). Roughly one-third of states (8 of 25 states in 2005) reported that the P&T Committee also considers other factors, such as the availability of therapeutic alternatives.

The primary purpose of a PDL is to assist a state in controlling pharmaceutical spending. The net cost to the state is clearly an important consideration. In setting up their PDLs, however, several states do not permit the P&T Committee to see cost information, believing that the committee's role should be focused on providing an expert review of clinical evidence. In these states, the P&T Committee may determine whether a class of drugs should be placed on the PDL, and only after the fact does the state use cost considerations in determining which specific drugs in the class to include on the list. The majority of states (22 of 25 states in 2005) reported that the state considers the cost of drugs separately from the review conducted by the P&T Committee.



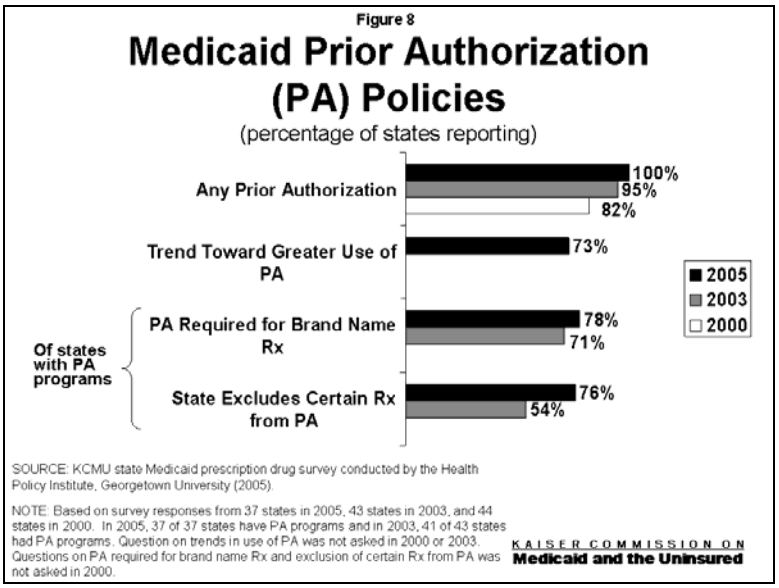
PRIOR AUTHORIZATION

Tables 9-11

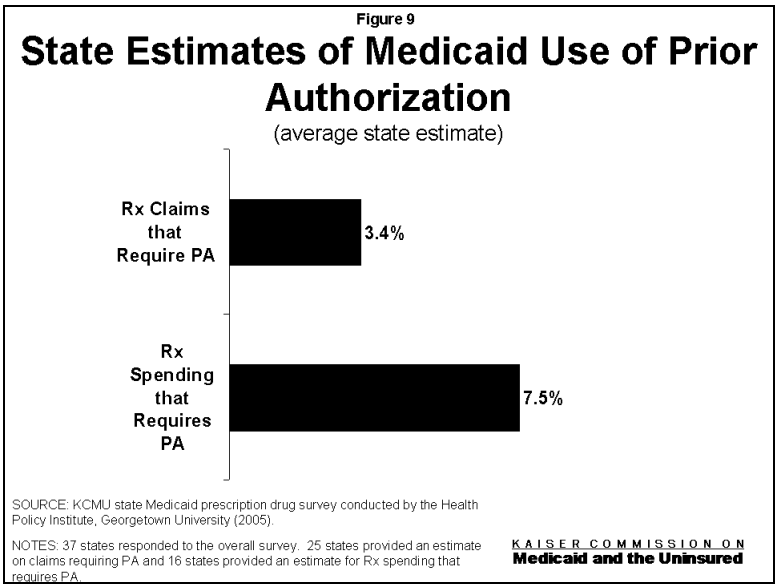
The Medicaid law permits states to subject any covered outpatient prescription drug to prior authorization (PA).[17] States must respond to requests for authorization within 24 hours (by telephone or otherwise) and, except for excludable drugs, they must dispense at least a 72-hour supply of a requested drug in cases of an emergency (as defined by the Secretary).[18]

Prior Authorization (PA): Policy of a state Medicaid program that requires a pharmacist to obtain approval from the state (or a subcontractor) before dispensing a drug.

In 2005, all 37 responding states required PA for at least some prescription drugs covered by Medicaid **(Figure 8)**. Moreover, roughly three-fourths of respondents (27 of 37 states in 2005) reported that the recent trend has been toward a greater reliance on PA. One common practice is for states to require PA for brand name drugs when a generic equivalent is available. Most states (29 of 37 states in 2005) reported that they require PA in this circumstance for at least some drugs. Additionally, most states (28 of 37 states in 2005) exclude certain classes of drugs from PA. States commonly exempted cancer medications, antiretrovirals used in the treatment of HIV/AIDS, and some or all classes of mental health drugs from PA.



PA is a central pharmacy cost containment strategy in virtually all states, but states use it selectively. The average estimate is that only 3.4% of prescription drug claims are for drugs that require PA (based on estimates from 25 states in 2005) **(Figure 9)**. Additionally, the average estimate is that only 7.5% of Medicaid prescription drug spending is for drugs that require PA (based on estimates from 16 states). Some policy makers may consider these low percentages to indicate that states could require PA for far more drugs. The success of PA, however, may hinge upon targeting efforts appropriately because PA programs can be administratively cumbersome for states, and a greater use of PA may decrease support for the program from stakeholders including physicians, pharmacists and beneficiaries. The size and extent of state PA programs varies substantially. State estimates of the number of PA requests in the last year ranged from a low of 100 in South Dakota to nearly one million in California (see Table 10). Administrative capacity to review large volumes of PA requests (as in California, with its hundreds of thousands of requests per year) and how such capacity is financed is a factor in determining the extent of PA use in a given state.



GENERIC SUBSTITUTION

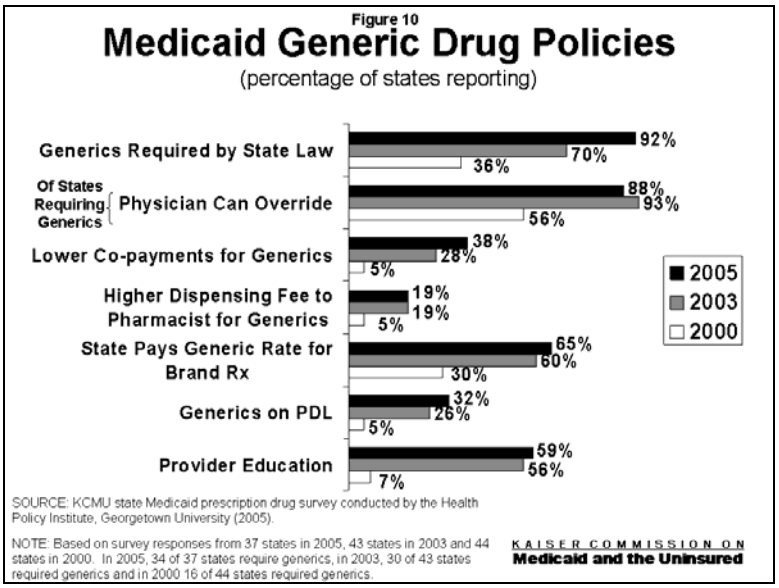
Tables 12-13

As discussed previously, Medicaid law generally requires states to provide coverage for all FDA-approved medications made by manufacturers with rebate agreements in effect with the federal government. Medicaid law does not, however, prevent states from requiring or encouraging the use of generic medications.

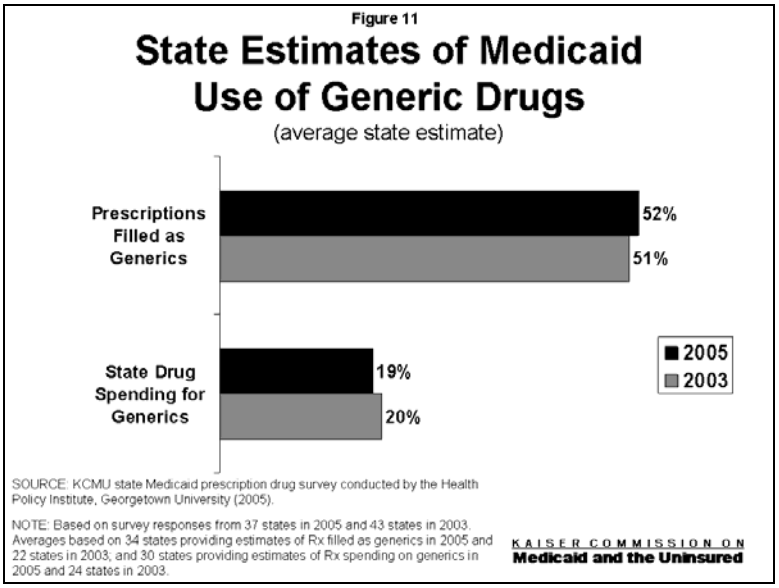
Since 2000, there has been a steady trend toward increased mandatory generic substitution. In 2005, nearly all states (34 of 37 states in 2005) reported that they require generics to be dispensed when available **(Figure 10)**. The majority of these states (30 of 34 states in 2005), however, permit this requirement to be overridden based on the professional judgment of the treating physician. Generally, this requires the prescriber to write "Brand Medically Necessary" on the prescription.

Generic Drug: A generic drug is identical, or bioequivalent to a brand name drug in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use. Although generic drugs are chemically identical to their branded counterparts, they are typically sold at much lower prices than branded drugs.

Additionally, states undertake a variety of strategies to encourage the use of generics. These include charging a lower co-payment for generics (14 of 37 states in 2005); paying a higher dispensing fee when pharmacists dispense generics (7 of 37 states in 2005); paying the generic rate for brand name prescription drugs (24 of 37 states in 2005); placing generics on the PDL (12 of 37 states in 2005); and engaging in counter detailing or taking other steps to educate providers (22 of 37 states in 2005).



On average, states estimate that 52% of prescriptions are filled with generics (based on estimates provided by 34 states in 2005) **(Figure 11)** and that 19% of Medicaid drug spending is for generics (based on estimates provided by 30 states in 2005).



COST-SHARING
Table 14

Medicaid permits states to charge “nominal” cost-sharing to certain groups of beneficiaries for certain services. Medicaid law prohibits cost-sharing for the following groups: children under age 18; pregnant women with respect to services relating to pregnancy or any other medical condition that may complicate the pregnancy; terminally ill individuals receiving hospice care; and inpatients in hospitals, nursing facilities, or

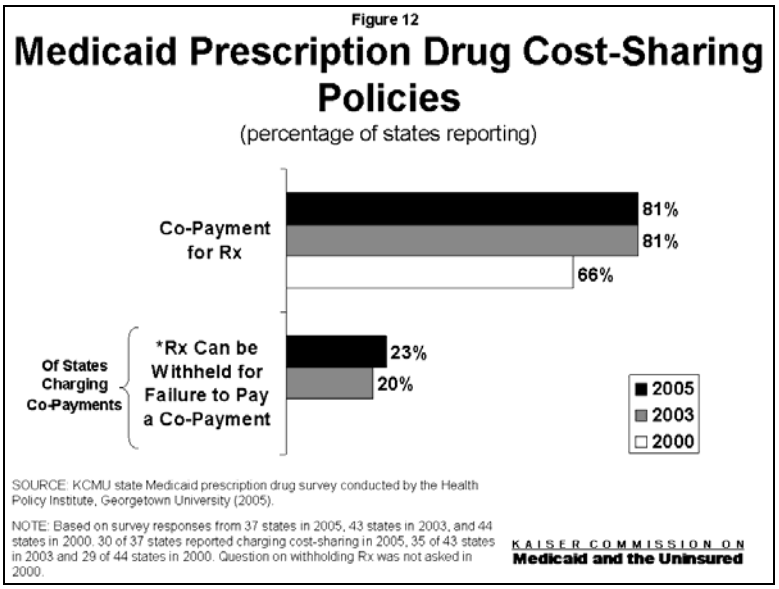
Cost-Sharing: Policy that requires a beneficiary to pay a portion of the cost of a service. In the case of prescription drugs, states may require certain Medicaid beneficiaries to pay a "nominal" co-payment, although a state cannot deny a beneficiary a drug based on the failure to pay the co-payment.

intermediate care facilities for persons with mental retardation (ICF/MRs) who are required to contribute all but a minimal amount of their income for their medical care.[19]

Four in five states charge co-payments for prescription drugs (30 of 37 states in 2005) **(Figure 12)**.

When cost-sharing is permitted, providers are prohibited from denying care or services to an eligible individual on account of an individual's inability to pay a co-payment.[20] Recently, CMS has taken the position that although states cannot refuse to provide prescription drugs or other services based on non-payment, they can deny prescription drugs when the beneficiary owes a debt to a provider (i.e., a pharmacy) or where there is a history of non-payment. Twenty three percent of states that impose cost-sharing report that they permit prescription drugs to be withheld (7 of 30 states in 2005), although three of these states (California, Florida, and Nebraska) reported that their withholding policies were pursuant to federal approval through a waiver.

Figure 12

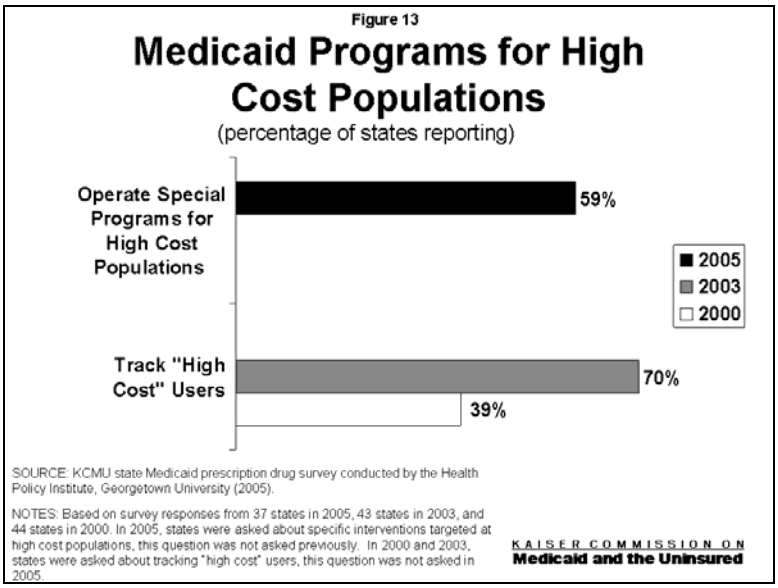


HIGH COST MANAGEMENT

Tables 15-16

As is the case with other Medicaid service use, prescription drug use is not distributed evenly among Medicaid beneficiaries. Rather, a relatively small number of people with disabilities and chronic conditions is responsible for a large share of overall Medicaid drug costs. Therefore, a number of states (23 of 37 states in 2005) report that they

operate special programs targeting high cost populations **(Figure 13)**. States take a variety of approaches in defining the target population for these interventions and for shaping the type of intervention **(see Table 15)**. Some states target high cost users based on claims data. Some states also identify certain chronic conditions (i.e., asthma, diabetes or congestive heart failure). States also employ a variety of strategies to address these populations. Common types of interventions include disease management programs and provider education.



PURCHASING POLICIES

Tables 17-18

States have considerable discretion in setting payment rates for Medicaid outpatient prescription drugs. The price Medicaid pays for drugs has three components:

1) the amount the state pays the pharmacist for the drug itself;
2) the amount of the dispensing fee that that state pays the pharmacist for filling the prescription; and,
3) the size of the rebate that the state receives from the drug manufacturer for purchasing the drug.

Payment for the drug itself: The Medicaid law does not set any minimum payment standards, but it does establish maximum payments for which states can receive a federal match.

For brand name drugs (i.e. drugs still under patent), and multi-source drugs with fewer than three therapeutically equivalent generics, the maximum payment cannot exceed the lesser of the drug's estimated acquisition cost (EAC) plus a dispensing fee or the provider's usual and customary charges to the general public. Each state determines its own EAC, which in most states is based on the average wholesale price (AWP).

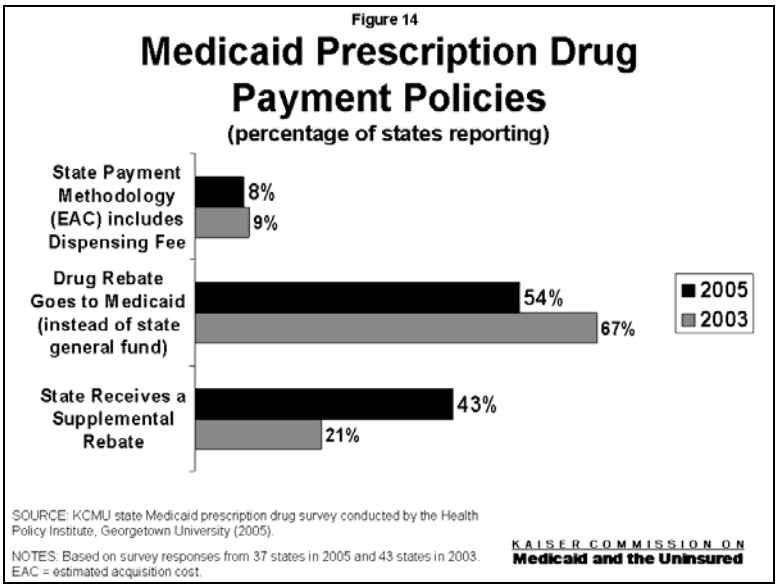
AWP is set by the drug manufacturer as a suggested price that wholesalers charge retail pharmacists for the drug. Most states set their EAC as AWP minus some percentage discount. The actual cost paid for drugs by pharmacies is generally believed to be well below AWP, providing a justification for the discount. A 1999 study by the HHS Office of the Inspector General estimated that the actual acquisition cost for pharmacies was AWP – 21.84%[21] which is considerably lower than what states typically pay. A smaller number of states set their EAC based on the wholesale acquisition cost (WAC), an estimate of the wholesaler's cost for the drug plus a percentage add-on.[22] Recently, federal policy makers have considered proposals to set a federal standard for Medicaid pharmacy payments, relying on the average manufacturer's price (AMP) and the average sales price (ASP). Both of these measures have the advantage of being based on actual prices paid for pharmaceuticals.

For generic drugs (i.e., multi-source drugs with at least 3 therapeutic equivalents), federal matching payments are limited by the Federal Upper Limit (FUL). The FUL is set at 150% of the published price for the least costly therapeutic equivalent that can be purchased by pharmacists in quantities of 100 tablets or capsules.[23] Medicaid regulations stipulate, however, that the FUL payment ceiling does not apply if a prescribing physician (in his or her own handwriting) specifies that a specific brand is medically necessary.[24]

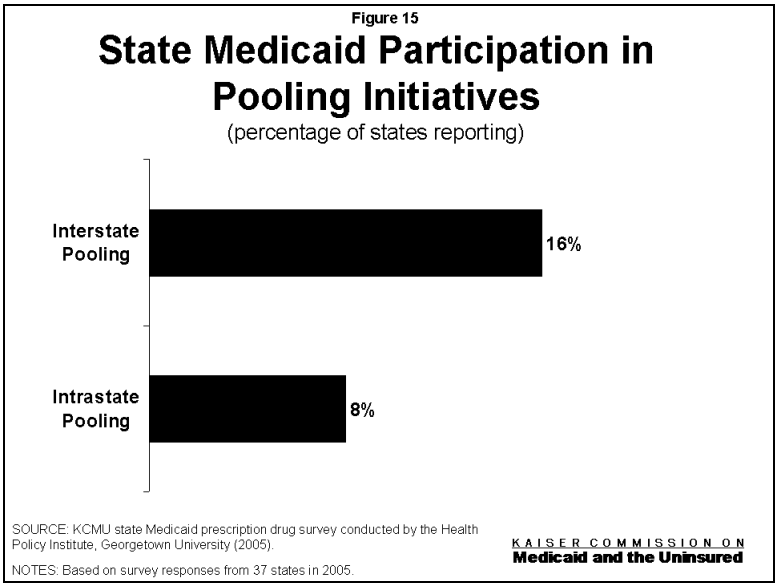
Dispensing fee: The Medicaid law and the payment ceilings described above permit states to pay a "reasonable" dispensing fee to the pharmacist. Federal regulations do not define what is reasonable, and there is significant variation in the fees paid by states.

Drug rebates: The actual cost to Medicaid for prescription drugs is reduced by manufacturers' rebates to states. The federal rebate is based on agreements between manufacturers and the Secretary of HHS, is uniform across the states, and is shared with the federal government. Some states, however, have negotiated supplemental rebates directly with manufacturers. The federal rebate extends only to drugs purchased by states on a fee-for-service basis. When states purchase drugs through capitated managed care programs, the managed care organizations are permitted to negotiate their own discounts.

When states receive drug rebate payments, it is at their discretion to return these funds to Medicaid or apply them to the state's general fund. A little more than half of the states return the rebate payment to Medicaid (20 of 37 states in 2005); a decline from 2003 when 29 of 43 states reported that rebate payments went to Medicaid. Fewer than half of the states, but a growing number, receive supplemental rebates (16 of 37 states in 2005, compared with 9 of 43 states in 2003). In addition, relatively few states (3 of 37 states in 2005) include their dispensing fee when calculating the EAC **(Figure 14)**.



Recently, there has been a growing interest by states to try to leverage their market share by pooling programs to receive larger rebates or better prices on prescription drugs. States can do this by pooling purchasing across several states (6 of 37 states in 2005) and by pooling purchasing for multiple state programs, including Medicaid and other state programs such as State Pharmacy Assistance Programs (SPAPs) (3 of 37 states in 2005) **(Figure 15)**.



IMPACT ON MEDICAID OF MEDICARE DRUG COVERAGE

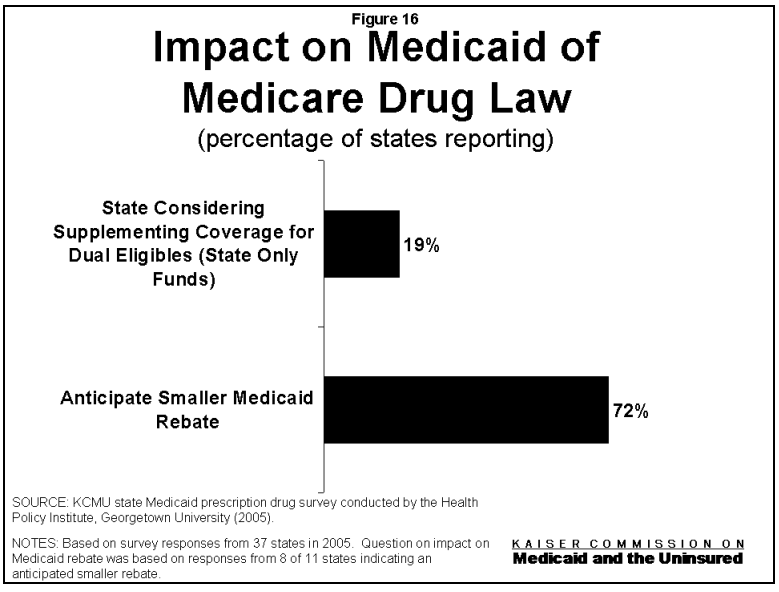
Table 19

The implementation of the Medicare Modernization Act (MMA) has the potential to improve access to prescription drugs for millions of Medicare beneficiaries. The impact

on dual eligibles, however, is unclear. Dual eligibles' prescription drug coverage through Medicaid will end on December 31, 2005 and Medicare Part D drug coverage will begin on January 1, 2006. CMS in its rulemaking and subsequent guidance has taken steps to ensure that Medicare Part D plan formularies are comprehensive. This includes telling plans that they must cover all or substantially all drugs in six key classes:

- Anticonvulsants;
- Antidepressants;
- Antineoplastics;
- Antipsychotics;
- Antiretrovirals, and;
- Immunosuppressants

Nonetheless, states and many affected stakeholders are concerned that coverage gaps will arise for dual eligibles, both because plans will not cover necessary medications or because drugs will be denied due to the inability to pay cost-sharing. Some states (7 of 37 states in 2005) reported that they are actively considering using state-only funds to fill in gaps in Medicare coverage **(Figure 16)**. While many state respondents said that they could not anticipate the impact on Medicaid of the implementation of the MMA, of those responding, nearly three-fourths indicated a belief that Medicaid programs would receive smaller rebates due to the loss of market share (8 of 11 states responding to this question in 2005).



Of the 35 states that listed issues they considered most important to the dual eligibles' transition from Medicaid to Medicare drug coverage, items related to education and communication ranked first, including beneficiary education, outreach to providers, and outreach to state employees. Issues related to enrollment, including auto-enrollment

and issues related to formularies and potential state wrap-around were the next most frequently mentioned items.

CONCLUSION

The importance of prescription drugs in the clinical management of many health conditions continues to grow with the discovery of new medications and with improvements to existing therapies. The promise of new therapeutics lies in the potential to bring new treatments to previously untreatable or poorly treated conditions and in improving the quality of life of many individuals—while reducing other costs in the health system.

For state Medicaid programs, the prospect of a future with new and improved drugs must also be balanced with the daunting challenge of financing the provision of these medications. Until now, Medicaid has played a unique role in providing access to prescription drugs to the neediest and costliest cohorts of Americans (low-income people with severe disabilities and low-income elderly individuals). Medicaid programs have responded to increased drug spending through selective application of utilization management strategies, coupled with patient protections that are required by law. Beginning in 2006, this responsibility will be shared with the Medicare Part D prescription drug program which has more latitude to limit access to drugs.

Medicaid programs are faced with the concurrent challenges of facilitating a smooth transition for dual eligibles to the Part D program and grappling with Part D's impact on prescription drug costs and access for the remainder of the Medicaid population. Meanwhile, the Congress is considering changes to how prescription drugs are purchased through Medicaid and how much cost beneficiaries should bear. In the midst of these changes, access to vital drugs for many of the poorest and sickest Americans should not be sacrificed.

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[1] *National Health Expenditures Tables, 2003*, Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, January 2005.
[2] *National Health Expenditures Tables, 2003,* Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, January 2005.
[3] *Prescription Drug Trends*, Henry J. Kaiser Family Foundation, October 2004.
[4] *National Health Expenditures Tables, 2003,* Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, January 2005.
[5] Congressional Budget Office, March 2005 Baseline.
[6] The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), also called Medicare Part D (Public Law 108-173), creates a right for Medicare beneficiaries to purchase Medicare prescription drug coverage beginning on January 1, 2006. While technically voluntary, low-income Medicare beneficiaries who also receive Medicaid (dual eligibles) will lose their Medicaid drug coverage and will be automatically enrolled in a Medicare prescription drug plan.
[7] John Holahan and Arunabh Ghosh, *Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2003*, Kaiser Commission on Medicaid and the Uninsured, July 2005.
[8] For ease of reference, throughout this report, references to "states" should be inferred to include the District of Columbia.
[9] For 2003 survey, go to http://www.kff.org/medicaid/4164.cfm. For 2000 survey, go to http://www.kff.org/medicaid/2225-index.cfm.
[10] §1903(i) of the Social Security Act. See first sentence after (20).
[11] 42 CFR 440.230 (d).

[12] §1927(d)(6) of the Social Security Act.
[13] §1927(d)(4) of the Social Security Act.
[14] The following drugs or classes of drugs (or their medical uses) may be restricted from coverage or otherwise restricted: 1) Drugs when used for anorexia, weight loss, or weight gain; 2) drugs when used to promote fertility; 3) drugs when used for cosmetic purposes or hair growth; 4) drugs when used for the symptomatic relief of coughs and colds; 5) drugs when used to promote smoking cessation; 6) prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations; 7) nonprescription drugs; 8) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee; 9) barbiturates; and, 10) benzodiazepines.[14] (Note: These listed exclusions were enacted into law in the Omnibus Budget Reconciliation Act of 1990 and are sometimes referred to as "OBRA exclusions" or "OBRA-90" exclusions.)
[15] §1927(d)(4)(C) of the Social Security Act.
[16] §1927(d)(4)(E) of the Social Security Act.
[17] §1927(d)(1)(A) of the Social Security Act.
[18] §1927(d)(5) of the Social Security Act.
[19] §1916(a)(2) of the Social Security Act.
[20] §1916(e) of the Social Security Act.
[21] Office of the Inspector General, *Medicaid Pharmacy – Actual Acquisition Cost of Brand Name Prescription Drug Products* (August 10, 2001) (A-06-00-00023) http://oig.hhs.gov/oas/reports/region6/60000023.htm.
[22] Schneider A and Elam L. *Medicaid: Purchasing Prescription Drugs*. Kaiser Commission on Medicaid and the Uninsured, January 2002.
[23] 42 CFR 447.332(b).
[24] 42 CFR 447.331(c).

STATE-BY-STATE TABLES

Table 1: Medicaid Enrollment, 2005, by State.

STATE	*# of Medicaid Beneficiaries*	*# of Medicaid Beneficiaries in Institutions*	*# of Dual Eligibles in Institutions*
Alabama			
Alaska	120,000	837	729
Arkansas	596,010	13,625	N/A
Arizona	1,047,448	8,557	7,701
California	5,416,948	124,715	98,237
Colorado	425,000	Unknown	N/A
Connecticut	120,506	25,278	N/A
Delaware			
District of Columbia	138,996	1,880	N/A
Florida	2,300,000	80,000	N/A
Georgia			
Hawaii			
Idaho	165,909	3,631	N/A
Illinois	1,911,880	94,216	31,558
Indiana	985,910	47,490	39,480
Iowa	299,927	N/A	N/A
Kansas	300,000	N/A	20,000
Kentucky			
Louisiana	1,048,021	36,891	
Maine			
Maryland	584,000	16,000	12,800
Massachusetts	965,000	N/A	N/A
Michigan	1,374,200	33,000	31,000
Minnesota	466,827	47,569	38,196
Mississippi	72,000	21,134	N/A
Missouri	990,552	25,239	N/A
Montana			
Nebraska	201,533	8,570	7,838
Nevada			
New Hampshire	103,000	4,874	4,254
New Jersey	932,000	30,000	28,600
New Mexico			
New York*	4,631,204	149,784	N/A
North Carolina	1,137,506	96,293	64,911
North Dakota	52,800	3,500	3,325
Ohio			
Oklahoma	528,499	N/A	29,999
Oregon	395,000	5,300	4,800
Pennsylvania	2,078,650	83,766	N/A
Rhode Island			
South Carolina	1,018,552	18,000	N/A
South Dakota	97,000	3828	N/A
Tennessee			
Texas	2,786,387	69,658	N/A
Utah	294,528	5817	N/A
Vermont			
Virginia	804,163	24,270	15,484
Washington	447,395	59,591	20,000
West Virginia			
Wisconsin	400,000	25,000	N/A
Wyoming	58,176	5,430	3,183

Notes: Shaded states did not participate in the survey. N/A = not available. *New York's numbers are from FY 2003.

Table 2: Medicaid Average Monthly Per Capita Prescription Drug Use, 2005, by State.

STATE	*Average # of Rx per Person*	*Average # of Rx per Dual Eligible*	*Average # of Rx per Institutionalized Individual*
Alabama			
Alaska	N/A	N/A	N/A
Arkansas	3.0	N/A	7.4
Arizona	N/A	N/A	N/A
California	N/A	N/A	N/A
Colorado	N/A	N/A	N/A
Connecticut	N/A	N/A	5
Delaware			
District of Columbia	4.19	N/A	N/A
Florida	2.2	N/A	5.8
Georgia			
Hawaii			
Idaho	4.16	N/A	N/A
Illinois	1.11	4.31	5.84
Indiana	1.43	5.41	10.3
Iowa*	2	N/A	N/A
Kansas	N/A	N/A	N/A
Kentucky			
Louisiana	5.2	N/A	6.1
Maine			
Maryland	3	6	6
Massachusetts	N/A	N/A	N/A
Michigan	N/A	N/A	N/A
Minnesota	2.11	5.24	2.9
Mississippi	N/A	N/A	N/A
Missouri	N/A	N/A	14.4
Montana			
Nebraska	N/A	N/A	N/A
Nevada			
New Hampshire	2	10.4	5
New Jersey	N/A	N/A	N/A
New Mexico			
New York	12	N/A	N/A
North Carolina	4.2	N/A	N/A
North Dakota	4.14	6.13	N/A
Ohio			
Oklahoma	3.09	3.09	7.22
Oregon	2.5	N/A	N/A
Pennsylvania	N/A	N/A	N/A
Rhode Island			
South Carolina	N/A	N/A	N/A
South Dakota	N/A	N/A	N/A
Tennessee			
Texas	1.14	N/A	7.63
Utah	0.93	N/A	6.35
Vermont			
Virginia	1.17	4.17	6.92
Washington	5.49	7.17	7.91
West Virginia			
Wisconsin	4.5	5	10
Wyoming	3.57	7.3	N/A
AVERAGE (n=# of states)	**3.32** (n=22)	**5.8** (n=11)	**7.17** (n=16)

Notes: Shaded states did not participate in the survey. N/A = not available. *Iowa's average number of Rx per person is based on 24.44 per year and assumes full year enrollment.

Table 3: Medicaid Prescription Drug Spending, 2005, by State.

STATE	*Rx Spending Last Year (in millions)*	*Rate of Rx Growth Last Year (SFY '04)*	*Projected Rx Growth in Current Year (SFY '05)*	*Rx Spending Last Year for Dual Eligibles (in millions)*	*Rx Spending Last Year for Institutionalized Individuals(in millions)*	*% of Rx Spending for Institutionalized Individuals*	*Institutional Rx Carved Out of Institutional Rate*
Alabama							
Alaska	$114.0	17%	24%	$44.6	$3.2	3%	•
Arkansas	$363.2	21%	19%	N/A	$71.3	16%	
Arizona	$316.8	N/A	N/A	$129.8 (FY '02)	N/A	N/A	•
California*	$4,202.8	14.7%	14%	$257.5	N/A	N/A	
Colorado	$270.0	14%	N/A	$135.0	N/A	N/A	
Connecticut	$432.7	14.2%	7.3%	N/A	N/A	22%	•
Delaware							
District of Columbia	$105.3	18%	20%	$75.4	N/A	7.2%	•
Florida	$2,400.0	12%	12-14%	$1,200.0	$260.0	10.0%	•
Georgia							
Hawaii							
Idaho	$146.9	12.6%	13.8%	$67.0	N/A	N/A	
Illinois	$1,500.0	10.7%	20.9%	$573.0	$327.5	21.3%	•
Indiana	$724.6	0%	11.7%	$382.5	$182.6	25.2%	•
Iowa	$361.7	12.3%	11.1%	$179.3	N/A	N/A	
Kansas	$300.0	12%	15%	$100.0	$133.0	33.0%	•
Kentucky							
Louisiana	$881.3	15.2%	17%	$288.0	$174.5	20.0%	•
Maine							
Maryland	$372.0	17%	16%	$210.0	$85.9	23.0%	•
Massachusetts	$960.0	0%	5%	$500.0	$130.0	13.0%	•
Michigan**	$642.2	11.3%	4.2%	$403.5	$78.2	12.0%	•
Minnesota	$417.0	2.4%	2%	$217.0	$105.0	20.0%	•
Mississippi	$547.0	21%	23%	$325.0	$71.0	13.0%	
Missouri	$1,077.6	14.4%	15.3%	$509.0	$509.0	14.4%	•
Montana							
Nebraska	$208.1	4.5%	8%	$112.4	$26.4	12.2%	•
Nevada							
New Hampshire***	$126.3	15.1%	15.8%	$74.1	$27.6	25.0%	•
New Jersey	$960.0	18%	16-18%	$570.0	N/A	12-13%	
New Mexico							
New York****	$4,548.0	9.1%	N/A	$1,700.0	$132.6	N/A	•
North Carolina	$1,481.6	24.0%	24.0%	$790.8	N/A	N/A	
North Dakota	$58.9	-3.0%	12%	$17.6	$20.9	37.0%	•
Ohio							
Oklahoma*****	$367.0	10%	28%	$176.0	$74.8	26.0%	•
Oregon	$449.0	6%	1.18%	N/A	N/A	N/A	•
Pennsylvania	$896.6	18.6%	13.9%	$533.1	$264.6	N/A	•
Rhode Island							
South Carolina	$620.5	17.7%	16.3%	N/A	$30.0	5-7%	•
South Dakota	$80.2	18%	16.7%	N/A	N/A	N/A	•
Tennessee							
Texas	$2,202.1	15.8%	10.8%	N/A	$357.4	16.2%	
Utah	$183.2	18.6%	14.8%	N/A	$22.5	12.2%	•
Vermont							
Virginia	$611.0	N/A	N/A	N/A	$114.0	30%	
Washington	$680.0	9.5%	8.5%	$307.0	$180.0	7.0%	•
West Virginia							
Wisconsin	$374.0	14%	12%	N/A	$150.0	25.0%	
Wyoming	$50.0	15.8%	19.2%	$22.0	$14.0	28.0%	
TOTAL/AVERAGE	—	**12.9%** (n=35)	**14.3%** (n=33)	—	—	**18.2%** (n=27)	**25**

Notes: Shaded states did not participate in the survey. N/A = not available. N=# of states. *California: Institutionalized Rx spending not carved out of Institutional rates except for OTCs and insulin. **Michigan: Spending numbers for "last year" are for SFY '03 and for "current year" are for SFY '04. ***New Hampshire: Rx spending in institutions includes Rx spending for home- and community-based care. ****New York: Dual spending levels are for SFY '03. Institutional Rx are carved out of institutional rate for selected drugs only. *****Oklahoma: High rate of growth in Rx spending for current year is due to the transition of 115,000 beneficiaries from managed care to receiving state plan services.

Table 4: Medicaid Prescription Drug Dispensing Limits, 2005, by State (1 of 3 Tables).

STATE	***Amount of Rx****	*Exempted Populations or Classes*	***# of refills***	*Exempted Populations or Classes*	*Action When Limit is Reached*	*# of Times Limit Reached in the Last Year*
Alabama						
Alaska	30 Days	OC				
Arkansas	30 Days					
Arizona	30 Days, 100 Days for chronic illness & contraception					
California	100 Days or smaller	Sodium Fluoride tablets				
Colorado						
Connecticut	30 Days non-maintenance		•	Scheduled drugs	New Prescription Required	
Delaware						
District of Columbia	31 Days (some have quantity limits)	LTC	•		New Prescription Required	358,112
Florida	34 Days					
Georgia						
Hawaii						
Idaho	•	Children's multi vitamins, birth control, cardiac glycosides, thyroid drugs, iron salts & prenatal vitamins	•		PA Required	N/A
Illinois	30 Days					
Indiana	34 Days	Mental Health, Narrow therapeutic index	•	Mental Health Narrow therapeutic index	PA Required	500-1000
Iowa	30 days	9 legend classes, OTCs				
Kansas	•		•	After 1 year, new prescription required		
Kentucky						
Louisiana	•		•	Scheduled, New Drugs		
Maine						
Maryland	34 Days		•	N/A		N/A
Massachusetts	90 Days		•		Drug Denied	Unknown
Michigan	34 Days		•		PA Required	None
Minnesota	34 Days	OC				
Mississippi	34 Days		•		Drug Denied	

STATE	***Amount of Rx****	*Exempted Populations or Classes*	***# of refills***	*Exempted Populations or Classes*	*Action When Limit is Reached*	*# of Times Limit Reached in the Last Year*
Missouri	•	•				
Montana						
Nebraska			•			N/A
Nevada						
New Hampshire	30 days	Maintenance Rx				
New Jersey	34 Days, 100 units		5 in 6 months		New Prescription Required	N/A
New Mexico						
New York	•		•		New Prescription Required	N/A
North Carolina	34 Days	FP, Hormones	•		MD completes form based on medical evidence	Pharmacies keeps count not State
North Dakota**	34 Days					
Ohio						
Oklahoma	•		34 Days, 100 Units			
Oregon***	34 Days	Selected Maintenance Drugs				
Pennsylvania	34 Days, 100 units		•	New Rx, 5 refills in 6 months		
Rhode Island						
South Carolina	34 Days					
South Dakota	34 Days	FP				
Tennessee						
Texas	34 days unlimited plan		5 in 6 months	Family Planning		N/A
Utah	31 Days					
Vermont						
Virginia	34 Days					
Washington	30-34 Days	Mail order, package size, FP		Risk of suicide, overdose	Medical Evidence	1610
West Virginia						
Wisconsin	34 Days	Some 100day generic drugs	•	Alert can be overridden	PA Required	N/A
Wyoming	34 Days, 90 units	•				
TOTAL	**35**		**16**		**2 = Denied**	

Notes: Shaded states did not participate in the survey. N/A = not available. OC = Oral contraceptives. FP = Family planning drugs. *Bullets (●) indicate that the state applies this limit, but the actual limit was not specified. **North Dakota: If primary insurance allows different amounts and they will pay the claim the 34 day limit is by passed. ***Oregon: Answers reflect fee-for-service benefit only, 15 drugs per patient in 180 days triggers clinical pharmacist review; recommendations can be enforced via withholding payment after Medical Director Review & DUR Board review.

Table 5: Medicaid Prescription Drug Dispensing Limits, 2005, by State (2 of 3 Tables).

STATE	***# of Rx***	*Exempted Populations or Classes*	*Action When Limit is Reached*	*# of Times Limit Reached in the Last Year*
Alabama				
Alaska				
Arkansas				
Arizona				
California	•	LTC, Contraceptives, Cancer Drugs	PA Required	4.4 million
Colorado				
Connecticut				
Delaware				
District of Columbia				
Florida*				
Georgia				
Hawaii				
Idaho	•	Cancer/ Terminal (pain management only)	PA Required	Unknown
Illinois				
Indiana				
Iowa				
Kansas	•	•	Medical Evidence	Unknown
Kentucky				
Louisiana	•	LTC <under 21 years of age, post partum	Drug Denied	N/A
Maine				
Maryland				
Massachusetts				
Michigan				
Minnesota				
Mississippi	•	LTC <21 years of age	Drug Denied	Unknown
Missouri				
Montana				
Nebraska				
Nevada				
New Hampshire				
New Jersey				
New Mexico				
New York	•	•		
North Carolina	•	Under 21 CAP program	MD completes form based on diagnosis	N/A
North Dakota				
Ohio				
Oklahoma	•	LTC, Kids, waiver, HCBS waiver	Drug Denied	921
Oregon*	•		See Note	1,200
Pennsylvania		New Rx, 5 refills in 6 months		
Rhode Island				
South Carolina	•	Life threatening illness, behavioral, organ failure		
South Dakota				
Tennessee				
Texas	•	<21, LTC, waiver, managed care	Drug Denied	N/A
Utah				
Vermont				
Virginia				
Washington	•	Generics require PA		33,502
West Virginia				
Wisconsin				
Wyoming				
TOTAL	**12**		**4 = Rx Denied**	

Notes: Shaded states did not participate in the survey. N/A = not available. *Oregon: Answers reflect fee-for-services only. 15 Rx per patient in 180 days triggers clinical pharmacist review; recommendations can be enforced by withholding payment after Medical Director review and DUR Board review.

Table 6: Medicaid Prescription Drug Dispensing Limits, 2005, by State (3 of 3 Tables).

STATE	***Different Dispensing Limits for Maintenance Rx***	*Definition of Maintenance Rx*	*Limits Applicable to Maintenance Rx*
Alabama			
Alaska Arkansas Arizona California	•	Rx for chronic illness	100 Days
Colorado	•		100 Days
Connecticut	•	Defined by PBM	240 Units
Delaware			
District of Columbia Florida			
Georgia Hawaii			
Idaho Illinois Indiana	•	Cardiac glycosides, thyroid replacement hormones, prenatal vitamins, fluoride, non-legend oral iron salts, and oral contraceptives	100 doses not to exceed a 100 day supply. Oral contraceptives may be supplied in quantity sufficient for up to three cycles
Iowa Kansas	• •	9 classes are specifically identified	90 Days
Kentucky			
Louisiana			
Maine			
Maryland Massachusetts Michigan Minnesota Mississippi	• •	Defined by Medicaid Agency Defined by therapeutic class (e.g. antihypertensives and hypoglycemics)	100 Days 102 Days
Missouri			
Montana			
Nebraska			
Nevada			
New Hampshire	•	Routine daily therapy for at least 120 days	90 Days
New Jersey			
New Mexico			
New York North Carolina North Dakota	• 90 days for generics	Anticonvulsants, antidiabetics, antifungal agents, cardiac drugs, hormones, hypotensive agents, thyroid preparations, diuretics, antihyperlipidermics, anticholinergic and parasympathetic agents, and prescriptions on NYS triplicate prescription form	90 Days
Ohio			
Oklahoma Oregon Pennsylvania	•	Specified in rule by class	90 Days, 100 Tablets
Rhode Island			

STATE	***Different Dispensing Limits for Maintenance Rx***	*Definition of Maintenance Rx*	*Limits Applicable to Maintenance Rx*
South Carolina			
South Dakota			
Tennessee			
Texas			
Utah			
Vermont			
Virginia			
Washington		Lifetime use for a chronic condition	
West Virginia			
Wisconsin			
Wyoming	•	Rx to treat chronic conditions over months or years	90 Days
TOTAL	**13**		

Notes: Shaded states did not participate in the survey.

Table 7: Medicaid Preferred Drug List (PDL) Policies, 2005, by State (1 of 2 Tables).

STATE	*State has PDL*	*Entity that Manages PDL*	*Entity that Sets PDL Inclusion Criteria*	*P&T Committee Inclusion Criteria*					*State Considers Cost as Inclusion Criteria*
				Clinical Efficacy	*Safety*	*Supplemental Rebate*	*Net Cost*	*Other*	
Alabama									
Alaska	•	State/Fiscal Agent	Division of Health Care Services	•	•		•	Class, Effect	•
Arkansas	•	State College of Pharmacy	P & T Committee	•	•				
Arizona*									
California	•	State	Medi-Cal	•	•		•	Essential need, Misuse potential	•
Colorado									
Connecticut									
Delaware									
District of Columbia									
Florida	•	State	State, P & T Committee	•	•	•	•	•	•
Georgia									
Hawaii									
Idaho	•	State	Dept. of Health & Welfare, State Legislature	•	•	•	•	Current use, OTC alternatives	•
Illinois	•	State	State	•	•				•
Indiana	•	PBM	State	•	•	•	•		•
Iowa	•	State/PBM	Dept. of Human Services	•	•	•	•		•
Kansas	•	State	State	•	•				•
Kentucky									
Louisiana	•	State	P & T Committee	•	•	•	•		•
Maine									
Maryland	•	State	State	•	•	•	•		•
Massachusetts	•	State		•	•		•		•
Michigan	•	State/PBM	State/P & T Committee	•	•				
Minnesota**	•	State	State	•	•				•
Mississippi	•	State	P & T Committee	•	•		•		
Missouri	•	Other	Contractor, DUR Board	•	•	•	•		•
Montana									
Nebraska									
Nevada									
New Hampshire	•	State, PBM	State, input from P&T	•	•			Therapeutic alternatives	•
New Jersey									
New Mexico									
New York									
North Carolina									
North Dakota									

STATE	State has PDL	Entity that Manages PDL	Entity that Sets PDL Inclusion Criteria	P&T Committee Inclusion Criteria					State Considers Cost as Inclusion Criteria
				Clinical Efficacy	Safety	Supplemental Rebate	Net Cost	Other	
Ohio									
Oklahoma	•	State	DUR Board	•	•	•	•	•	•
Oregon	•	State	Health Resources Commission	•	•			Drug effectiveness, Review project reports	•
Pennsylvania*									
Rhode Island									
South Carolina	•	State	P & T recommends to state, state looks at $	•	•				•
South Dakota									
Tennessee									
Texas	•	State Others	State administers P & T Advises	•	•	•	•	•	•
Utah									
Vermont									
Virginia	•	PBM	P & T recommends to state, state may amend	•	•	•	•		•
Washington	•	State	State	•	•				•
West Virginia									
Wisconsin	•	State	PBM recommends to state, Decision made by Health & Pharmacy services	•	•	•	•		•
Wyoming	•	Wyoming Dept. of Health	Wyoming Dept. of Health with input from PDL Advisory Committee	•	•				•
TOTAL	**25**			**25**	**25**	**11**	**15**	**8**	**22**

Notes: Shaded states did not participate in the survey. *Arizona and Pennsylvania: Decisions about operation of PDL and specific inclusion criteria made by individual MCOs; therefore, not included in total of states with PDLs. **Minnesota: State is participating in the National Medicaid Buying Pool that is managed by First Health Service Corp on behalf of 8 states: AK, HA, MI, MN, MT, NH, NV, TN (KY Pending).

Table 8: Medicaid Preferred Drug List (PDL) Policies, 2005, by State, (2 of 2 Tables).

STATE	*Frequency of Revisions to PDL*	*Public Input in PDL*	*Exempted Populations*	*PDL Used for Other State Programs*	*# of Requests for non-PDL Rx*	*# of Requests Denied*
Alabama						
Alaska	Semi-Annually	•		Yes, but not specified	15%	N/A
Arkansas	As Needed	•			N/A	N/A
Arizona	Continuously				N/A	N/A
California	Periodically	•			956,801	143,883
Colorado						
Connecticut						
Delaware						
District of Columbia						
Florida	Quarterly	•	LTC-Silver Saver Program		N/A	MD is never denied, may have to provide additional info
Georgia						
Hawaii						
Idaho*	Continuously (each class annually)	•	By age & disease state		8,060	1,944
Illinois	Quarterly			SCHIP	N/A	
Indiana	Bi-annually	•			84,000-120,000	Limited number
Iowa**	Quarterly	•			N/A	N/A
Kansas	Annually	•				
Kentucky						
Louisiana	Semi-annually	•			138,685	117
Maine						
Maryland	Quarterly	•	MCO users, mental health patients	Yes, but not specified	68,076	232
Massachusetts	Monthly				N/A	N/A
Michigan	Continuously (each class annually)	•	MCO users	State Pharmacy Assistance, Children's Special Health Care Services, Maternal Outpatient Medical Services	165,000	1,500
Minnesota***		•	MCO users	State Pharmacy Assistance	N/A	N/A
Mississippi	Bi-monthly					
Missouri	Continuously	•			9,215	4,462
Montana						
Nebraska						
Nevada						
New Hampshire****	As needed	•			N/A	N/A
New Jersey						
New Mexico						
New York						
North Carolina						
North Dakota						
Ohio						

STATE	*Frequency of Revisions to PDL*	*Public Input in PDL*	*Exempted Populations*	*PDL Used for Other State Programs*	*# of Requests for non-PDL Rx*	*# of Requests Denied*
Oklahoma	Continuously	•		SCHIP		
Oregon	Quarterly, New Info	•	Mental health, oncology, and HIV populations	SCHIP	N/A	N/A
Pennsylvania						
Rhode Island						
South Carolina	Just began, every 2 months then to quarterly			Children categories	N/A	
South Dakota						
Tennessee						
Texas	Bi-annually					
Utah						
Vermont						
Virginia	Bi-annually, new availability	•	MCO, SCHIP, State mental facilities		37,000	0
Washington	Annually, new availability	•		State employees, SCHIP, workmen's comp	124,330	17,406
West Virginia						
Wisconsin	Quarterly meetings, updated annually	•		State Pharmacy Assistance		
Wyoming	Annually, drugs added quarterly	•	Under 21	State Pharmacy Assistance	N/A	N/A
TOTAL		**20**		**11**		

Notes: Shaded states did not participate in the survey. N/A = not available. *Idaho: Public input in PDL received by public testimony at P&T meetings. **Iowa: PDL was implemented on 01/15/2005, thus no data on number of requests or denials. ***Minnesota: There is a 15 day comment period following each meeting by which pharmaceutical manufacturers, MD's and advocacy groups may submit materials to staff after to meetings to influence the PDL. ****New Hampshire: PDL was only fully implemented in December 2004; thus, no data are available.

Table 9: Medicaid Prescription Drug Prior Authorization (PA) Policies, 2005, by State (1 of 3 Tables).

STATE	*Any PA*	*PA for Brand Name Rx*	*Specified PA Exclusions*
Alabama			
Alaska	•		
Arkansas*	•	•	
Arizona	•	•	Some exclusions, but not specified
California	•		Some exclusions, but not specified
Colorado	•	•	
Connecticut**	•	•	Organ transplant
Delaware			
District of Columbia	•	•	HIV drugs are covered by a special waiver
Florida	•		Some exclusions, but not specified
Georgia			
Hawaii			
Idaho	•	•	Varies based on therapeutic class
Illinois***	•	•	HIV, Cancer
Indiana	•	•	Mental health, Narrow therapeutic index
Iowa	•	•	
Kansas	•	•	Some exclusions, but not specified
Kentucky			
Louisiana	•		Some exclusions, but not specified
Maine			
Maryland	•	•	Antiretrovirals, Atypical antipsychotics
Massachusetts	•	•	Some exclusions, but not specified
Michigan	•	•	Anticonvulsants, antidepressants, antipsychotics, antiretrovirals, cancer chemotherapy, other non-controlled substances, Rx for mental health
Minnesota	•	•	Hemophilia, atypical antipsychotic
Mississippi		•	Cox II's
Missouri	•	•	Cancer, HIV
Montana			
Nebraska	•	•	
Nevada			
New Hampshire***	•	•	Most are excluded
New Jersey	•	•	
New Mexico			
New York	•	•	Coumadin, Gengraf, Sadimmune, Clozaril, Lanoxin, Tegretol, Dilantin, Neoral, Zarontin
North Carolina	•		Some exclusions, but not specified
North Dakota	•	•	Cancer, HIV, and mental health
Ohio			
Oklahoma****	•	•	
Oregon*****	•	•	Some exclusions, but not specified
Pennsylvania	•	•	Limited number of drugs
Rhode Island			
South Carolina^	•	•	Cancer, HIV, and mental health
South Dakota	•		
Tennessee			
Texas	•	•	Hemophilia and HIV
Utah	•	•	Coumadin
Vermont			
Virginia	•		
Washington	•	•	Cancer, HIV, family planning, low cost drugs
West Virginia			
Wisconsin^^	•	•	Antidepressants for mental health
Wyoming^^^	•		Varies by class
TOTAL	**36**	**29**	**28**

Notes: Shaded states did not participate in the survey. *Arkansas: Decisions made by individual MCO. **Connecticut: Requires PA for AB-rated brand name drugs. ***Illinois and New Hampshire require PA for some, but not all brand name Rx. ****Oklahoma: Requires PA for brand name Rx for multisource brand Rx. *****Oregon: Enforcement of PDL with PA is prohibited. Clinical DUR Board is allowed. ^South Carolina: Requires PA for brand name Rx when AB-rated generic available. ^^Wisconsin: Inclusion criteria for specific drug depends on drug, fail first and fail twice policy, clinical criteria, and medically necessity. ^^^Wyoming: Legislature has authorized PA for brand name Rx, but it is not yet implemented.

Table 10: Medicaid Prescription Drug Prior Authorization (PA) Policies, 2005, by State (2 of 3 Tables).

STATE	*Estimated Prescriber Time Burden Per Request*	*# of PA Requests in Last Year*	*# of PA Denials in Last Year*	*Process for Appealing a PA Denial*
Alabama				
Alaska	< 5	3,627	5	Request fair hearing
Arkansas	< 5	154,894	N/A	Request fair hearing
Arizona	N/A	N/A	N/A	Appeal to MCO and then appeal at the State level
California	N/A	956,801	143,833	1st appeal to Medi-Cal office, 2nd appeal must be submitted within 30 days of denial
Colorado	< 15	2,400		Send appeal letter , appear in person or phone
Connecticut	< 15	687,362	572	Administrative process, request fair hearing
Delaware				
District of Columbia	< 15	10,018	250	MD writes appeal, fax to HSC forward to MAH
Florida	< 5	36,000	7,200	MD calls Pharmacy Bureau, appeal via Fair hearing process
Georgia				
Hawaii				
Idaho	< 5	85,567	4,458	Written request from patient
Illinois	< 15			Request fair hearing
Indiana	N/A	48,000-72,000	1,200-2,400	Formal appeal to Hearing and Appeals department
Iowa*	<15	60,000	3,175	
Kansas	< 5			Request fair hearing
Kentucky				
Louisiana	< 5	138,685	117	MD must follow-up
Maine				
Maryland	5-15	150,000	1,500	Provide additional documentation stating medical necessity
Massachusetts	< 5	176,000	880	Request fair hearing
Michigan	<5	230,000	3,000	Prescriber resubmits request with more info; fair hearing
Minnesota**	< 5	25,352	4,334	See note below
Mississippi	N/A	217,536	18,522	MD's review, denial sent to patient, 30 days to request hearing
Missouri	< 5	87,060	36,530	Patient must call or write within 90 days requesting fair hearing
Montana				
Nebraska		25,772	6,940	Provide additional documentation to State
Nevada				
New Hampshire	< 5	11,741	212	Request fair hearing
New Jersey	< 5	715,000	35,783	Request fair hearing
New Mexico				
New York	< 5	628,553	None	Not applicable
North Carolina	< 5	49,015	10,342	Request fair hearing, Letter
North Dakota	< 5	1,000 approved		Patient can appeal not provider
Ohio				
Oklahoma	< 5	114,932	41,000	Initial review by pharmacist, then review by DUR Board
Oregon	N/A	409,292	8,288	Request fair hearing. Medical Director decides if hearing needed.
Pennsylvania	< 15	12,948 (6 months)	1260	Department maintains appeals process
Rhode Island				
South Carolina	< 5	N/A	N/A	Fill out form, then request fair hearing
South Dakota	N/A	100	None	Request fair hearing
Tennessee				
Texas	< 5			Request for reconsideration; request fair hearing
Utah	N/A	N/A	N/A	Appeal to DUR Board
Vermont				
Virginia	< 5	<500	N/A	Beneficiary or physician may appeal with state
Washington	< 5	61,032	9276	Request fair hearing
West Virginia				
Wisconsin	< 5	N/A	N/A	Denial letter sent with appeal instructions
Wyoming	< 15	8,561	1,868	Provider can appeal via website; request fair hearing

Notes Shaded states did not participate in the survey. N/A = not available. *Iowa: The number of PA requests and denials was prior to the implementation of the PDL. Minnesota: Patient can file an appeal heard by referees. If appeal denied, patient can pursue action in court. Informally, prescribers are referred to a DHS pharmacist for consideration of unusual cases.

Table 11: Medicaid Prescription Drug Prior Authorization (PA) Policies, 2005, by State (3 of 3 Tables).

STATE	*Trends in Use of PA, Past 2 Years*	*Trends in Ease of Granting PA, Past 2 Years*	*% of Rx Claims that Require PA*	*% of Rx Spending for RX that Require PA*
Alabama				
Alaska	More	No Change	1.0%	5.0%
Arkansas	More	More Transparent	N/A	N/A
Arizona	More	N/A	N/A	N/A
California	More	No Change	6.5%	12.7%
Colorado	More	No Change	10.0%	N/A
Connecticut	Less	Harder	1.4%	N/A
Delaware				
District of Columbia	More	No Change	8.4%	10.6%
Florida	More	No change	N/A	N/A
Georgia				
Hawaii				
Idaho	More	Easier	7.3%	12.6%
Illinois	More	No Change	2.6%	4.5%
Indiana*	More	No Change	0.7%	10.0%
Iowa	More	No change	<1%	N/A
Kansas	More	Easier		
Kentucky				
Louisiana	Less	No Change	1.0%	N/A
Maine				
Maryland	More	No Change	< 1%	< 1%
Massachusetts	No Change	No Change	N/A	N/A
Michigan	More	No Change	2-3%	N/A
Minnesota	More	No Change	N/A	N/A
Mississippi	More	Harder	7.7%	15.6%
Missouri	More	Easier	4.9%	N/A
Montana				
Nebraska	No Change	No Change	0.005%	N/A
Nevada				
New Hampshire	More	No Change	0.5%	18.0%
New Jersey	More	No Change	<10%	N/A
New Mexico				
New York	More	No Change	1.0%	1.3%
North Carolina	Less	No Change	N/A	N/A
North Dakota	Program just began	No Change	6.1%	4.8%
Ohio				
Oklahoma	More	No Change	N/A	N/A
Oregon	More	No Change	3.0%	7.0%
Pennsylvania		No Change	N/A	N/A
Rhode Island				
South Carolina	More	No Change	<5%	N/A
South Dakota	More	No Change	3.0%	3.0%
Tennessee				
Texas	More	Harder	N/A	N/A
Utah		No Change	0.8%	3.3%
Vermont				
Virginia**	No Change	No Change	1.0%	1%
Washington	More	Easier	1.0%	10.0%
West Virginia				
Wisconsin	More	No Change	N/A	N/A
Wyoming	More	No Change	N/A	N/A
AVERAGE (n=# of states)	**27 = More**		**3.4%** (n=25)	**7.5%** (n=16)

Notes: Shaded states did not participate in the survey. N/A = not available. In calculating averages, where <# was indicated, the upper maximum was used. 1% was used for all responses less than 1%. *Indiana: %of Rx claims requiring PA and % of Rx spending for Rx that require PA excludes PDL requests. **PA referenced here is for non-PDL PA for weight loss and pulmonary arterial hypertension medications.

Table 12: Medicaid Generics Policies, 2005, by State (1 of 2 Tables).

STATE	Generics Required		Generics Encouraged				
	Generics Required	Physician Can Override	Lower Co-Pays for Generics	Higher Dispensing Fee to Pharmacist	State Pays Generic Rate for Brand Rx	Generics on PDL/ Formulary	State Educates Physicians on Generics
Alabama							
Alaska	•	•				•	
Arkansas	•	•		•	•	•	
Arizona*	•	•					
California							
Colorado	•	•					•
Connecticut	•						•
Delaware							
District of Columbia**	•	•			•		
Florida	•	•			•	•	
Georgia							
Hawaii							
Idaho***	•				•	•	•
Illinois	•		•	•	•		
Indiana	•	•				•	•
Iowa	•	•			•		•
Kansas****	•	•			•		•
Kentucky							
Louisiana	•	•			•	•	•
Maine							
Maryland	•	•	•	•	•	•	•
Massachusetts	•	•	•			•	
Michigan****							
Minnesota*****	•	•	•		•		•
Mississippi	•	•	•			•	•
Missouri	•	•			•		
Montana							
Nebraska	•	•			•		
Nevada							
New Hampshire	•	•	•		•		
New Jersey	•	•					•
New Mexico							
New York	•	•	•	•			•
North Carolina***	•	•	•	•	•		
North Dakota	•	•	•	•	•		•
Ohio							
Oklahoma	•	•				•	•
Oregon^	•	•	•		•		•
Pennsylvania	•	•			•		•
Rhode Island							
South Carolina	•	•			•		•
South Dakota	•	•	•		•		
Tennessee							
Texas^^	•	•		•	•		•
Utah^^^	•						
Vermont							
Virginia	•	•	•		•	•	•
Washington	•	•			•		•
West Virginia							
Wisconsin^^^^	•	•	•		•	•	•
Wyoming^^^^^			•		•		•
TOTAL	**34**	**30**	**14**	**7**	**24**	**12**	**22**

Notes: Shaded states did not participate in the survey. N/A = not available. AB rated generics are those that meet an FDA standard for bioequivalence to the brand name product. *Arizona: Decisions made by individual MCO. **District of Columbia: Pays generic rate for brand names only if PA is not obtained. ***Idaho and North Carolina: Pays generic rate for Brand Rx if part of State MAC. ****Kansas and Michigan: Physicians can override generic requirement only with PA. *****Minnesota: PA is required for all brands if AB rated generic is available. ^Oregon: Requires generic when AB rated generic is available. Physician can override, but "medically necessary" must be written. ^^Texas: All pharmaceuticals must be on PDL list including generics. ^^^Utah: PA is required for brand if generics available. ^^^^Wisconsin requires generics for Rx on extensive MAC list. Wyoming is in the process of implementing a new MAC policy in which generics will be required.

Table 13: Medicaid Generics Policies, 2005, by State (2 of 2 Tables).

STATE	*Estimated % of Rx Filled as Generics*	*Estimated % of Total Rx Spending for Generics*
Alabama		
Alaska	41%	5%
Arkansas	47%	18%
Arizona	71%	N/A
California	52%	16%
Colorado	54%	19%
Connecticut	42%	16%
Delaware		
District of Columbia	46%	14%
Florida	46%	18%
Georgia		
Hawaii		
Idaho	54%	21%
Illinois	61%	26%
Indiana	53%	N/A
Iowa	51%	30%
Kansas	60%	28%
Kentucky		
Louisiana	57%	26%
Maine		
Maryland	50%	26%
Massachusetts	57%	20%
Michigan	56%	15%
Minnesota	57%	19%
Mississippi	43%	20%
Missouri	55%	20%
Montana		
Nebraska	55%	16%
Nevada		
New Hampshire	50%	15%
New Jersey	48%	N/A
New Mexico		
New York	43%	N/A
North Carolina	50%	16%
North Dakota	55%	15%
Ohio		
Oklahoma	57%	21%
Oregon	61%	20%
Pennsylvania	47%	18%
Rhode Island		
South Carolina	N/A	N/A
South Dakota	46%	15%
Tennessee		
Texas	N/A	N/A
Utah	51%	18%
Vermont		
Virginia*	55%	20%
Washington	60%	21%
West Virginia		
Wisconsin	N/A	N/A
Wyoming	48%	17%
AVERAGE (n=# of states)	**52%** (n=34)	**19%** (n=30)

Notes: Shaded states did not participate in the survey. N/A = not available. Virginia: Based on data through May 2005.

Table 14: Medicaid Prescription Drug Cost-Sharing Policies, 2005, by State.

STATE	*Cost-Sharing for Rx*	*Co-Pay Amount*	*Exempted Populations or Rx**	*Rx Withheld for Failure to Pay Co-Pay*	*Withholding Pursuant to Waiver*
Alabama					
Alaska	•	$2.00	Native Americans		
Arkansas	•	$0.50 - $3.00			
Arizona**		See note	Native Americans	See note	
California	•	$1.00 in certain circumstances	Elderly, Parents of Foster children		•
Colorado	•	$1.00 Generic, $1.00 Brand			
Connecticut					
Delaware					
District of Columbia	•	$1.00	MCO		
Florida	•	$2.00 Generic, $5.00 PDL drugs, $10.00 Non-PDL		•	•
Georgia					
Hawaii					
Idaho					
Illinois	•	$3.00 Brand			
Indiana	•	$3.00			
Iowa	•	$1.00 Generic, $0.50-$3.00 Brand			
Kansas	•	$3.00			
Kentucky					
Louisiana	•	Drugs 0.00-$10.00 pay .50, Drugs $10.01-$25.00 pay $1.00, Drugs $25.01-$50.00 pay $2.00			
Maine					
Maryland	•	$1.00 Generic, $2.00 Brand			
Massachusetts	•	$1.00 Generic, $3.00 Brand			
Michigan***	•	$1.00 Generic, $3.00 Brand	Prenatal vitamins	See note	
Minnesota***	•	$1.00 Generic, $3.00 Brand		See note	
Mississippi	•	$1.00 Generic, $2.00 Preferred sole source, $3.00 Non-preferred sole source,			
Missouri****	•	$.50, $1.00, or $2.00 depending on Ingredients	Elderly, disabled		
Montana					
Nebraska	•	$2.00		•	•
Nevada					
New Hampshire	•	$1.00 Generic, $2.00 Brand	Home- and community-based care		
New Jersey					
New Mexico					
New York					
North Carolina	•	$1.00 Generic, $3.00 Brand			
North Dakota	•	$3.00 Brand	Insulin		
Ohio					
Oklahoma	•	$1.00 if Rx is < $30, $2.00 if Rx is > $30.00			
Oregon	•	$2.00 Generic, $3.00 Brand			
Pennsylvania	•	$1.00 Generic, $3.00 Brand			
Rhode Island					

STATE	*Cost-Sharing for Rx*	*Co-Pay Amount*	*Exempted Populations or Rx**	*Rx Withheld for Failure to Pay Co-Pay*	*Withholding Pursuant to Waiver*
South Carolina	•	$3.00			
South Dakota	•	$0 Generic, $3.00 Brand		See note	
Tennessee					
Texas					
Utah	•	$3.00			
Vermont					
Virginia	•	$1.00 Generic $3.00 Brand			
Washington					
West Virginia					
Wisconsin	•	$1.00 Generic $3.00 Brand After $12.00 of total co-pay per month no charge			
Wyoming	•	$1.00 Generic, $2.00 Preferred, $3.00 non-preferred		Can refuse fill if occurs frequently	
TOTAL	**30**			**7**	**3**

Notes: Shaded states did not participate in the survey. N/A = not available. FP= Family Planning. *Federal law does not permit states to charge cost-sharing to children and pregnant women. **Arizona: State has been enjoined from charging cost-sharing pending resolution of on-going litigation. ***Michigan, Minnesota, and South Dakota: Pharmacist may refuse anyone who has a debt. Pharmacist must notify patients that no further services will be provided until debt is paid. ****Missouri: Only patients with specific types of eligibility are required to also pay a co-pay of $5.00 or $9.00 depending on eligibility. *****Oregon: Answers reflect fee-for-service drug benefit only.

Table 15: Medicaid Policies for Managing High Cost Beneficiaries, 2005, by State. (1 of 2 Tables).

STATE	*Program for High Cost Populations*	*Type of Program*	*Target Population*	*Type of Intervention*
Alabama				
Alaska	•	Behavioral Medication Management	Mental Health	Education letters to prescribers
Arkansas				
Arizona*				
California	•	Management of High Users	High Hospital Users & ER Users	Case Management
Colorado				
Connecticut				
Delaware				
District of Columbia	•	Management of High Users, Prescriber Education	High users found via drug file	DUR Outreach via Hospital & Private Contractor
Florida				
Georgia				
Hawaii				
Idaho	•	General Prescriber Education	Outliers based on claims & data	Academic detailing
Illinois	•	General Prescriber Education	Claims history of mental health drug users	Educational letters to prescribers
Indiana	•	Management of High Users	Asthma, Diabetes, Congestive heart failure	Phone calls, In person education , General support to primary care MDs
Iowa	•	Management of high users, management of high prescribers, General prescriber education		
Kansas				
Kentucky				
Louisiana				
Maine				
Maryland	•	General Prescriber Education	Review Utilization	Provider Mailing
Massachusetts				
Michigan				
Minnesota				
Mississippi	•	Disease Management, Prescriber Education	N/A	N/A
Missouri	•	Disease Management	Diabetes, Asthma, Heart failure, Depression	Pharmacy & patient medical team
Montana				
Nebraska				
Nevada				
New Hampshire				
New Jersey				
New Mexico				
New York	•	1-Disease Management, 2-Management of High Users, 3-Management of High Prescribers, 4-General Prescriber Education	1 & 3 Diabetes, Asthma, Sickle Cell, Peptic Ulcer	2- Alert from pharmacists, alert from MDs 3- Alert to MDS, Recipient Restriction Program- High users must receive care from a designated primary provider. This is a version of the Federal Lock-in- Program.
North Carolina	•	Disease Management		
North Dakota	•	Disease/Case Management	High cost recipients	Disease/Case Management
Ohio				

STATE	*Program for High Cost Populations*	*Type of Program*	*Target Population*	*Type of Intervention*
Oklahoma	•	Disease Management, General Prescriber Education, Management of High Users	Drug utilization reports	Education & monitoring
Oregon	•	Disease Management, Management of High Users, Management of High Prescribers, General Prescriber Education	Disease State Management: Diabetes, Asthma, and Congestive Heart Failure	Case management, education, and monitoring
Pennsylvania				
Rhode Island				
South Carolina	•	Disease Management, General Prescriber education	Disease Management – Diabetes, Asthma	Education of prescriber & patient
South Dakota	•	General Prescriber education	Behavioral Health	
Tennessee				
Texas				
Utah	•	1-Disease Management, 2-Management of High Users, 2-Management of High Prescribers	Per claim data	Peer review
Vermont				
Virginia	•	1-Behavioral pharmacy management program 2-Polypharmacy program	All recipients with state pharmacy benefits excluding MCO enrollees	1-Data reporting, letters to outlier prescribers, peer review 2-Alert to pharmacy providers, targeted utilization review, letters to prescribers
Washington	•	Disease Management, Management of High Users, Management of High Prescribers, General Prescriber Education	Collection of pharm. Paid claims data	Targeted drug review
West Virginia				
Wisconsin	•	General prescribe education class	Chronic illness, most appropriate to treat	Newsletter from DUR Board to MD's, Pharm & patient
Wyoming	•	1-Disease Management, 2-Management of High Users, 3- Management of High Prescribers, 4- General Prescriber Education		Targeted letters to groups 1,2 3, 4, Academic detailing for groups 3 & 4
TOTAL	**22**			

Notes: Shaded states did not participate in the survey. N/A = not available. *Arizona: Decisions made by individual MCO.

Table 16: Medicaid Policies for Managing High Cost Beneficiaries, 2005, by State. (2 of 2 Tables).

STATE	*Management of Program*	*Implementation of Program*	*Estimated Cost Savings in Millions*	*Achieved Outcomes and Goals*
Alabama				
Alaska	State & Contractor	2005	$500,000	N/A
Arkansas				
Arizona				
California	State	Various Programs	N/A	
Colorado				
Connecticut				
Delaware				
District of Columbia		Pending		
Florida				
Georgia				
Hawaii				
Idaho	Private Contractor, University	1/1/05	N/A	On Track
Illinois	Private Contractor	10/04	N/A	
Indiana	State	7/1/03		Yes
Iowa				
Kansas				
Kentucky				
Louisiana				
Maine				
Maryland	Private Contractor	DUR Board	N/A	Yes
Massachusetts				
Michigan				
Minnesota				
Mississippi		NA		
Missouri	Private Contractor	3/01/03	$1.1	Yes
Montana				
Nebraska				
Nevada				
New Hampshire				
New Jersey	Private Contractor	Not yet		
New Mexico				
New York	1,2,3, & 4 State runs program	2- 1995 3- 1992	1-Significant 2- FY 03 $140 million 3- $3000 per recipient	1,2 & 3 –Yes
North Carolina				
North Dakota	Unknown-just authorized by legislature	2005-2006	N/A	
Ohio				
Oklahoma	State Employees		No calculations	
Oregon	Contractor/State	2002 and early 1990s	Disease management 2-4%	Yes
Pennsylvania			Disease management 3%, Prescriber feedback	2-4 Patients
Rhode Island				
South Carolina	State Employees, Private Contractor	FY 04	Unknown	
South Dakota	State Employees, Private Contractor	FY 04		
Tennessee				
Texas				
Utah	1-Private Contractor, 2 –University of Utah	1- 7/01/04 2- 9/01/02	N/A	2-Yes

STATE	*Management of Program*	*Implementation of Program*	*Estimated Cost Savings in Millions*	*Achieved Outcomes and Goals*
Vermont				
Virginia	1-Vendor 2-PBM	1-April 2005 2-October 2004	N/A	N/A
Washington	Private contractor, PBM	2/01/02	30, 4 Brand Cap	Yes
West Virginia				
Wisconsin	State Employees, Private Contractor, University	Education 1995, Asthma 1999		
Wyoming	1-State, 2- State Lock-in program, 3-State via DUR, 4 - Via DUR	1—7/01/04 2—9/01/02 3 & 4—OBRA 1993	1 & 2-Cost neutral 3 & 4-N/A	1- not yet assessed 2-achived goals 3 & 4 not achieved goals

Notes: Shaded states did not participate in the survey. N/A = not available.

Table 17: Medicaid Prescription Drug Purchasing Policies, 2005, by State (1 of 2 Tables).

STATE	*Estimated Acquisition Cost (EAC) in %*	*EAC Includes Dispensing Fee*	*Dispensing Fee in Dollars*	*Rebate Payments go to Medicaid*	*State Receives a Supplemental Rebate*
Alabama					
Alaska	AWP – 5%		$3.45-$11.46	•	•
Arkansas	AWP – 14% Brand, AWP – 20% Generic		$5.51	•	•
Arizona	Each MCO negotiates		Each MCO negotiates		Each MCO negotiates
California			$7.25, ICF/SNF $8.00 to 17%	•	•
Colorado	No EAC				
Connecticut	AWP – 12%, AWP – 40% for MAC drugs		$3.15		
Delaware					
District of Columbia	AWP -10%	•	$4.50		
Florida	AWP-15.4% or WAC + 5.75%		$4.23	•	•
Georgia					
Hawaii					
Idaho	AWP -12%		$5.00	•	•
Illinois	AWP-12% Brand, AWP-25% Generic		$3.40 Brand, $4.60 Generic		
Indiana*	AWP -12%, WAC - 20% Generic				
Iowa	AWP - 12%		$4.26	•	•
Kansas	AWP -13% Single Source, AWP - 27% Multi-source		$3.40		
Kentucky					
Louisiana	AWP -13% Independents, AWP – 15% Chains		$.00- $5.77	•	•
Maine					
Maryland	AWP -12% WAC + 8%, Direct + 8%		$3.69 Preferred, $2.69 Non-preferred, $4.69 LTC preferred and $3.69 LTC non-preferred		•
Massachusetts	WAC + 5%		$3.00 basic, $2.00 additional compound		
Michigan**	AWP -13.5% Independents, AWP – 15.1% Chains		$2.50/$2.75 for LTC	•	•
Minnesota	AWP – 11.5% or MAC				
Mississippi					
Missouri	Lesser of AWP –		Enhanced	•	•

STATE	*Estimated Acquisition Cost (EAC) in %*	*EAC Includes Dispensing Fee*	*Dispensing Fee in Dollars*	*Rebate Payments go to Medicaid*	*State Receives a Supplemental Rebate*
	10.43%, SMAC, FUL, WAC + 10%		$4.09		
Montana					
Nebraska	AWP - 12%		$3.27 - $5.00	•	
Nevada					
New Hampshire	AWP-16%	•	$1.75		•
New Jersey	AWP – 12.5%		$3.73-$4.07	•	
New Mexico					
New York	AWP- 12.5% Brand, AWP - 16.50% Generic		$3.50 Brand $4.50 Generic		
North Carolina	Lesser of AWP - 10%, SMAC or FUL	•	$4.00 Brand, $5.60 Generic, Selected OTC	•	
North Dakota	Lesser of AWP – 10%, WAC + 12.5%, U&C, MAC, or FUL		$4.60 Brand $5.60 Generic	•	
Ohio					
Oklahoma	AWP – 12%		Up to $4.15		
Oregon	Lesser of AWP – 15%, SMAC, or FUL		$3.50 Retail $3.91 Institution		•
Pennsylvania	AWP - 10%		$4.00	•	
Rhode Island					
South Carolina	AWP - 10%		$4.05	•	•
South Dakota	AWP - 10.5%		Unit dose dispensing $4.75- $5.55	•	
Tennessee					
Texas***	Lesser of AWP – 15% or WAC + 12%		$5.14	•	•
Utah	AWP – 15%		$3.90 Urban, $4.40 Rural	•	
Vermont					
Virginia	AWP – 10.25%		$3.75		•
Washington	AWP – 14% Brand, AWP – 50% Multisource with 5 or more labels		$4.20-$5.20		
West Virginia					
Wisconsin	AWP – 13% Brand, Generic on MAC		$4.38	•	•
Wyoming	AWP – 11%		$5.00	•	
TOTAL		**3**		**20**	**16**

Notes: Shaded states did not participate in the survey. N/A = not available. *Indiana: Reports that supplemental rebates are optional. **Michigan: Does not receive supplemental rebates directly, but participates in the National Medicaid Pooling Initiative to solicit supplemental rebates. ***Texas: Chain pharmacies are paid the lowest price for any package size within the 9 digit NDC costs with the central purchasing policy. Direct-DEAC is based on manufacturers reported direct cost.

Table 18: Medicaid Prescription Drug Purchasing Policies, 2005, by State (2 of 2 Tables).

STATE	*State Engages in Intrastate Pooling*	*Participating Agencies/ Programs*	*State Engages in Interstate Pooling*	*Participating States/Coalitions**
Alabama				
Alaska	•		•	National Medicaid Buying Pool
Arkansas				
Arizona				
California				
Colorado				
Connecticut				
Delaware				
District of Columbia				
Florida				
Georgia				
Hawaii				
Idaho				
Illinois				
Indiana				
Iowa				
Kansas				
Kentucky				
Louisiana				
Maine				
Maryland			•	Louisiana, Maryland, West Virginia, Wisconsin
Massachusetts			•	National Medicaid Buying Pool
Michigan			•	National Medicaid Buying Pool
Minnesota	•		•	National Medicaid Buying Pool
Mississippi				
Missouri				
Montana				
Nebraska				
Nevada				
New Hampshire			•	National Medicaid Buying Pool
New Jersey				
New Mexico				
New York				
North Carolina				
North Dakota				
Ohio				
Oklahoma				
Oregon**	•	See note below		
Pennsylvania				
Rhode Island				
South Carolina				
South Dakota				
Tennessee				
Texas				
Utah				
Vermont				
Virginia				
Washington				
West Virginia				
Wisconsin				
Wyoming				
TOTAL	**3**		**6**	

Notes: Shaded states did not participate in the survey. N/A = not available. *The National Medicaid Buying Poll consists of - AK, HA, MI, MN, MT, NH, NV, TN (KY Pending). *****Oregon: Intrastate purchasing program scheduled for implementation in 2005; no agencies committed and Medicaid is excluded.

Table 19: Medicaid Responses to the Implementation of the MMA, 2005, by State.

STATE	*State Plans to Supplemental Coverage for Dual Eligibles (State Only Funds)*	*Anticipated Impact of MMA on Rebate*	*Most Important Issues for Successful Duals Transition*		
			1	*2*	*3*
Alabama					
Alaska	•	Smaller Rebate	Enroll pharmacies in plan networks	Educate duals	Educate providers
Arkansas		N/A	System implementation	State plan changes	Data exchange with PDPs
Arizona		N/A	Coordination of care with Medicaid MCOs	Education and Outreach	Coverage of excluded Part D drugs
California	To Be Determined	Smaller Rebate	Randomized auto enrollment of duals	Clawback impact	Determine which drugs are part of the wraparound coverage
Colorado		N/A	Patient & Public education	Education of staff	Educate other Government state agencies
Connecticut	•	N/A	TBD	TBD	TBD
Delaware					
District of Columbia		N/A	Wraparound coverage decision	Outreach & Education	Clawback impact
Florida		Smaller Rebate	Informing all duals	Matching duals to appropriate geographic region	Auditing CMS calculations-Clawback
Georgia					
Hawaii					
Idaho	•	Smaller Rebate	State education for the public	Solid planning	PDP adequate coverage
Illinois	•	N/A			
Indiana		N/A	Data from PDPS	Patient history to PDP for treatment	CMS return data on enrollment status with recipients
Iowa	To Be Determined	N/A			
Kansas	To Be Determined		Adequate coverage	Appropriate enrollment	Education & communication
Kentucky					
Louisiana		N/A	Transition state employees	Educate duals families	Simple documentation on state requirements
Maine					
Maryland	To Be Determined	Smaller Rebate	Education	Adequate Drug coverage PDP	Ensure enrollment PDP
Massachusetts		N/A	TBD	TBD	TBD
Michigan		Unsure	No break in eligibility for pharmacy benefit	Ensuring continued access to comprehensive array of Rx	Modify clawback to factor in cost containment started in 2004
Minnesota		N/A	Monitoring eligible members	Maintain full drug coverage	Provide “donut” coverage
Mississippi		N/A	Automatic enrollment	Provider education & assistance	Patient education & assistance
Missouri		N/A	Automatic enrollment	Formulary coverage	Coordination of benefits
Montana					
Nebraska		N/A			
Nevada					
New Hampshire	•	No impact	Plans with broad formulary coverage		

STATE	*State Plans to Supplemental Coverage for Dual Eligibles (State Only Funds)*	*Anticipated Impact of MMA on Rebate*	*Most Important Issues for Successful Duals Transition*		
			1	*2*	*3*
New Jersey	To Be Determined	Smaller rebate	PBM selection	Automatic enrollment	Formulary coverage
New Mexico					
New York	To Be Determined	N/A	Enrollment process	Eligibility process	Extension of drug form
North Carolina		N/A	Outreach and education of duals		
North Dakota		N/A	Accurate calculation of clawback	Receiving timely info	Computer system changes
Ohio					
Oklahoma	•	No impact	Short enrollment period for duals	Formulary issues, patients stabilized on non-preferred Rx	Disenrollment for disruptive behavior
Oregon		No impact	Auto enrollment by 12/15/05	Choice of client new prescription to new formularies	Tribal, HCBS, & LTC network access with comprehensive coverage
Pennsylvania		N/A	Accurate calculation of clawback	LTC residents	OTC State coverage
Rhode Island					
South Carolina	Limited- $250.00 buy-in responsible for copay of 25%, waiver program 100-200 % of Federal Poverty	Smaller rebate	Enrollment by January 2006	Education of the public on the benefit	
South Dakota	Limited coverage to non part D drugs already covered	N/A	Automatic enrollment	Educate Pharmacists of billing changes	Place patients in correct drug priority if they differ
Tennessee					
Texas		N/A	Funding approved for excluded drugs	Education of duals on enrollment/ medications	Education of providers
Utah		N/A	N/A	N/A	N/A
Vermont					
Virginia		Decrease in federal and supplemental rebates	Continuity of coverage	Outreach & education	Proper coverage of Medicare Part B drugs
Washington		N/A	CMS included	Concern of switching PDP of PDL	Concern of enrolling nursing home patients with dementia
West Virginia					
Wisconsin	To Be Determined	N/A	TBD	TBD	TBD
Wyoming	To Be Determined	N/A	Easy enrollment process	Feds must delineate the plan	Determine formulary
TOTAL	**7**	**Smaller Rebate = 8**			

Notes: Shaded states did not participate in the survey. N/A = not available. TBD = To be determined.

1330 G Street NW, Washington, DC 20005
Phone: (202) 347-5270, *Fax:* (202) 347-5274
Website: www.kff.org/KCMU

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